TRENDS, MOTIVATIONS AND EXPERIENCES OF CZECH MIGRANT NURSES: A MIXED METHODS STUDY

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Declaration

I declare that this thesis is my own work.

The stated word count is 61 259 words, excluding the abstract, contents and appendices.

Signed Veronika Di Cara

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Abstract

The migration of nurses is currently an important political theme, and it is only expected to intensify in the future, because of the current demographic trends. Considering the facilitating policies and the differences between salaries, the intra-European migration of nurses is rather small, but its monitoring is not very exact. The migration of Czech general care nurses remains under-researched.

I used mixed research with explorative sequential design in this study. In the initial embedded qualitative strand, I interviewed informants with expert knowledge on the migration of Czech nurses. The second quantitative strand consisted of a survey of self-selected Czech migrating nurses using an electronic questionnaire. The last strand used a focus group technique with Czech nursing migrants to clarify some of the previously researched topics.

Some findings from this study are similar to the previously conducted research, and some differ substantially. Almost all of the respondents and participants felt that their professional skills improved because of their migration. More than half eventually returned to the Czech Republic, often they provided direct care in the Czech Republic, and mostly they reported not being able to utilize all of the new knowledge gained abroad. The main destination country was Saudi Arabia, therefore the respondents often cooperated with a recruiting agency. Their families were typically not involved in the decision to migrate and the migrants only rarely sent remittances home. Instead, they invested their earnings in real estate. Consistent with the literature, the professional communication in a foreign language and the different nursing practices of the destination country were rated as difficult. Findings from all three strands suggested that the nurses were transformed by the migration.

It is generally understood that nurses are vital for providing health care services, thus we should offer them motivating working conditions to prevent more extensive migration and use the potential of brain circulation.

Key words:

Czech general care nurses, professional migration, mobility, transformation, return migration

Contents

I grew up in socialist Czechoslovakia. What was behind the barbed wire fences and the patrolling soldiers with guns and dogs trained to attack humans did not bother us much. For a child, there was nothing behind the fence…

1 Chapter - Introduction

When I was deciding which topic to choose for my PhD thesis, many competing themes were well worth the attention within the Czech nursing profession and its ongoing development. Some of these were from clinical nursing, while others dealt with ethical issues in Czech nursing practice. I was interested in directly contributing to the practical aspects of current nursing in the Czech Republic (CR).

A combination of three factors formed my final choice, a choice which seems, in the end, surprisingly and inevitably distant from everyday nursing practice, with its procedures, guidelines and pathways. My personal and intimate knowledge of the reality of nursing migration gained by my repeated professional migration to different countries was the first factor. Secondly, through my professional activities, I had access to large groups of Czech nurses, including those with migration experience or migration intentions. Lastly, the theme of health care professionals´ migration and its consequences seemed to be receiving considerable attention from the experts and politicians around the year 2009 and I knew there was not much published information about Czech migrating nurses. I wanted to make the Czech migrating nurses and their amazing experiences abroad and back home known.

1.1 Problem statement and background

Within the last few decades the number of migrants in the world, including health care professionals and nurses[1], has been continually increasing (Dumont and Zurn, 2007), (OECD, 2010b), (OECD, 2015b), (UNFPA, 2016) and the majority of migrants is moving from low income countries to higher income ones (Hanson, 2010). The migration of nurses is a current political theme across the globe, because of its relation to the general shortage of health care professionals and the provision of quality care in different countries (Aiken et al., 2004), (Buchan and Perfilleva, 2006a), (OECD, 2010b). It is expected that this shortage will only

[1] Although the migration of health care professionals in general is an important issue, this study concentrates on the migration of nurses responsible for general care. The research was conducted on a group of Czech nurses responsible for general care.

worsen in the future, particularly because of the current demographic trends in the developed countries and the rise in expectations for what constitutes quality care (European Commission, 2008). Therefore, we can expect a further increase in the migratory flows of nurses. Considering the facilitating policies, the intra-European migration of people and nurses is rather small compared to the migratory flows of non-EU citizens, but monitoring of these flows is not very exact (Aiken et al., 2004), (Bach, 2007), (Ognyanova et al., 2012) and some flows may not be easily measurable.

Since wage disparities between the "old" European Union countries and the "new" EU8[2] countries exist in many sectors, including the health care sector (Vavreckova et al., 2006), experts predicted a strong flow of citizens to the old EU states after the EU enlargement in 2004 (Aiken et al., 2004). Wage difference is one of the most important pull factors that typically contribute to migration (Kingma, 2006), (Dywili et al., 2013), (Tjadens et al., 2013). However, the movement of nurses and other professionals out of the new states in the years following their accession to the EU was not as strong as predicted (Wiskow, 2006), (Buchan and Aiken, 2008a), (European Commission, 2011).

Most of the research in this field has been conducted mainly on Filipino, Indian and African nurses, and it has recently revealed their rather negative and exceedingly difficult initial experiences in the destination countries (Troy et al., 2007), (Alonso-Garbayo and Maben, 2009), (Newton et al., 2012), (Moyce et al., 2015). This confirmed my own experience that to migrate to another country as a registered nurse is a very difficult step, because the professional task of a nurse is to effectively solve the most personal issues with people in very vulnerable conditions and unexpected, challenging life situations. In the case of a migrating nurse, the communication between the nurse and the client is restricted by many additional factors. I became increasingly more interested in the forces driving the migration of Czech nurses, as well as the obviously quite strong forces restricting it, because Czech nurses seem to migrate less than other Eastern European nurses (Ujvarine et al., 2011), (Gurková et al., 2013), (Szpakowski et al., 2016). Even though it seems that Czech nurses have not yet internalized the "culture of migration," the current deterioration of local

[2] The Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia accessed the EU in May 2004.

working conditions of nurses (caused by an unprecedented shortage of nurses (Šrajbrová, 2016), (ČTK, 2016)) may facilitate rapid changes in this area. The results of Czech nurses´ migration and whether it has any benefits apart from personal financial gain intrigued me as well.

1.2 The historical role of Czech women

In order to explain the context of current Czech nursing, which was originally a typically female profession, it is necessary to briefly comment on the history of women in Czech society.

The right of Czech women to vote was legalized by the Czechoslovakian Constitution in 1920, around the same time as in many other developed countries (e.g. Germany, Canada, the United States of America, Great Britain, Sweden and Russia) (Boumová, unknown). A milestone for the role of women in Czech society, one which deviated from the otherwise similar development in the rest of western Europe, came after the Second World War, when the Czech Communist Party gained overall political power. According to the teachings of Marx and Engels, women needed to be fully involved in the labor market in order to cast off the economic oppression which they experienced in capitalism; and subsequently their subordination to men would cease. Then, women and men would be equal to each other. Interpreted from the gender perspective, the "Great October Revolution" of 1917 in Russia is seen as modernizing, supporting female emancipation and viewing women as part of production and as active citizens (Moghadam, 2003).

The planned national economy in early 1950ies desperately needed more workers. Therefore, the communists implemented largely accessible facilities for the collective upbringing of children (basically from birth until adulthood), legalized pregnancy termination and facilitated the higher education of women. Because salaries were then extremely low, a double income was necessary for a more comfortable family life. On the other hand, some aspects of the historically recognized roles of women and men were preserved, and at that time were not viewed in a more modern way (e.g. the prevalence of long paid maternal, not paternal, leave from work, or the officially unacknowledged role of men in the family sphere – such as the participation on rearing children or households activities (Šmausová, 2006)).

The reviewed feminist literature often describes the double load of women, when women fully participated in the labor market and at the same time were solely responsible for household activities such as cooking, cleaning and taking care of children (or the triple load, when we include the semi-expected official political activity of women) (Einhorn, 1993). But Šmausová correctly reminds us that men also had a "double load," since it was very common that the men had to compensate for flaws in the planned economy and the resulting habitual market deficiencies by building houses, repairing cars and household appliances, growing vegetables and farming animals (Šmausová, 2006). Naturally, some men were also active in official politics. Even though this enforced emancipation of Czech women indeed caused their independence from men and their perception of mutual equality, women were more emancipated as workers than as citizens (Einhorn, 1993).

The political changes in Eastern and Central Europe in the late 1980s are interpreted from the gender perspective as a type of revolution which supports the patriarchal model of "women staying in the families," staying dependent, with their main roles as wives and mothers (Moghadam, 2003).

In summary, the role of women in Czech society was rather analogous to that of western European women until the end of the Second World War. After that, Czech women were emancipated by the ruling political party as workers, but not as citizens, even though the communist ideals originally suggest the emancipation of citizens. For the following forty years, two generations of Czech women and men grew up in a political environment which declared the equality of men and women and emancipated women in the labor market, but strongly restricted any independent (unsupervised and unapproved) emancipation of citizens, regardless of their gender. After the political changes in 1989, the Czech population considered working women to be a norm and the concept of a "stay at home mom", beyond the three years of paid maternal leave for every woman, retained a slightly negative "bourgeois" connotation. Further, the society had troubles to accept the ideas of feminism imported from the West, and was largely unprepared to be active in building up or developing a society or a profession.

1.3 Development of Czech professional nursing

The beginning of Czech professional nursing dates back to 1874, when the first and only nursing school in the then Austro-Hungarian monarchy was founded in Prague[3]. The school was founded by well-known contemporary Czech writers, promoters of female rights, and it was ideologically and practically supported by the Club of Czech physicians. The school provided short-term professional theoretical courses and practical training in a hospital. The school functioned for seven years and prepared 234 nurses. In the year 1874, Florence Nightingale´s book on nursing care was translated into Czech.

Another nursing school opened in Prague in 1916, the program was two years long, prepared "diploma nurses," and the applicants initially had to be at least 20 years of age. After the foundation of Czechoslovakia, in 1920, the politicians invited American Red Cross nurses to further develop the nursing curriculum in the school. The graduates of this school lead the emancipation of Czech nursing in the upcoming years while they worked in hospitals and well-being clinics. In 1946, there were 32 secular nursing schools on the Czech territory. Some educated pediatric nurses and one prepared nurses for leadership roles.

In 1950, Czechoslovakia adopted the so called "Soviet model" for educating nurses and started to prepare nurses at four year nursing high schools (Kafková, 1992). The applicants were 15 years old and they graduated at the age of 18-19 as qualified nurses. Their curriculum consisted of approximately two years of general subjects and two years of professional subjects. This supplied Czech hospitals with large numbers of nurses, but many were immature and unprepared to fully assume the role of a nurse. However, in 1960 a master's program preparing nursing teachers was opened in Prague. Until its discontinuation in the early years of the 21st century, it prepared hundreds of nursing teachers who taught nursing subjects to the young nurses at the nursing high schools.

Attempts to catch up with the international nursing development started soon after the political changes in 1989; in 1992 Charles University in Prague opened a bachelor level

[3] At that that time Prague was a city in the Austro-Hungarian Empire

program for nurses. Since 2004, newly graduated Czech nurses have been required to obtain a tertiary education.

1.4 Rationale for the selected topic

The main purpose of this study was to explore the important aspects of the migration of Czech nurses, because this topic has been under-researched, and many issues, such as the nurses' personal experiences, their outflow, and their return numbers, have not been previously explored or published.

The objective of this study was to contribute to filling the substantial gap in our knowledge of most aspects of the migration of Czech nurses. It added to the knowledge base concerning Czech nurses´ migration patterns and behavior, and also contributed to the broader understanding of EU mobility of health professionals. It could assist the Czech policy makers to better understand the current trends in the out-migration of Czech nurses, and to respond appropriately while planning for the future workforce of Czech nurses. In addition, other researchers could use the data collected on this specific subgroup of the Czech population, since other such data are currently not available. At a more local level, health care managers could potentially promote a more efficient utilization of returning nurses´ skills.

This thesis described the current trends in the migration patterns of Czech general care nurses, their motives for migrating out of the Czech Republic and their experiences as migrants. I decided to conduct a mixed methods research study in an attempt to capture in depth all of the many aspects of the health professionals' experiences as migrants, which is currently a global phenomenon with many ambiguous consequences for all players involved. In the first strand of this study I started by interviewing a representative from a recruitment agency, which sends Czech nurses abroad, as well as a representative of the governmental Register of health care professionals. An absence of any comprehensive published or reported data concerning the out-migrating nurses required me to establish a baseline level of information from these two experts.

In the second strand I collected quantitative information from Czech nurses responsible for general care who worked outside of the Czech Republic at some point of their career. Here, I used a self-administered electronic questionnaire to collect the quantitative data.

The last strand used a focus group technique to explore some of the previous findings in depth, give them more substance and promote a more complete understanding of the obtained results. The participants were migrating Czech nurses responsible for general care.

Given the mixed research character of this study, I have chosen to write this thesis in the first person singular to acknowledge my previous personal experience with professional migration.

In autumn 2010 I started to write a research journal, where I irregularly entered my ideas, thoughts, reflections, worries, questions, reminders, progress and further steps to be taken. Given the part time mode in which I studied and which prolonged the study period up to 6 years, it was a very helpful tool to recall many details and reasons for taking certain steps, as well as to see the development of my own research skills, experience and confidence.

1.5 Definition of key terms

Throughout this thesis I have used some key terms which I define in Chapter 7. A few of the fundamentally important terms are also defined below.

The terms “migration” and “mobility” are used interchangeably in this thesis, although mobility more often refers to migration within the EU.

The term “nurse responsible for general care” comes from Directive 2005/36/EC on the recognition of professional qualification, where the qualification of the “nurse responsible for general care” is described (European Parliament, 2005). For the purpose of this study, the term “Czech nurse responsible for general care” describes a nurse that obtained her/his first nursing qualification in the CR (or previously the Czechoslovak Socialist Republic). The term “Czech nurse” is its shorter version.

The term “host country”, and its synonyms “destination country” and “receiving country,” are used interchangeably in this thesis. All three terms describe a country where the nurse intends to work after migrating to it. Similarly, the term “source country” has a few synonyms: “country of origin”, “sending country” or “home country,” and it describes a country where the nurse lived and/or worked before migrating. Often, but not always, it is the country where the nurse obtained her/his first nursing qualification. Again, I used all four terms interchangeably in this thesis.

In this thesis I used the abbreviation “EU15” for the original countries forming the EU before 2004 (Belgium, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, United Kingdom and Austria, Finland, Sweden). I labeled the group of post-communist countries accessing the EU after 2004 as “EU8” (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia) intentionally excluding Cyprus and Malta which also accessed in 2004, but had different economic and historical conditions. Bulgaria and Romania accessed the EU in 2007; because of their similar history and conditions with the EU8 countries I grouped them together as “EU10”. Croatia accessed the EU in 2013, but because of the later accession date I did not refer to Croatia in my thesis.

Throughout this thesis I tried to refer to nurses while acknowledging both genders. Occasionally, for the sake of brevity, and slightly influenced by the fact that my research sample in all strands was dominated by female nurses, I only used the feminine form. However, I do acknowledge the increasing ratio of male nurses worldwide and also, with a certain delay, in Czech nursing a well.

1.6 Summary

This first introductory chapter has presented the reasons for choosing this topic, as well as its background and sociopolitical context. It specifies the studied problem, describes its overall significance and mentions the methods used to research it. This chapter also defines some key terms and summarizes the contents of each chapter.

Chapter two (Literature review) is dedicated to a review of the relevant literature, with an accent on nurses´ experiences of migration and return migration, as well as the consequences of migration for all involved parties. The few available studies conducted on Central and Eastern European nurses are noted, including unpublished Czech masters and bachelor theses, which were, until now, very much the only sources of information on Czech migrating nurses.

In the third chapter (Methods), I have described the selected research design and its appropriateness for the topic of nursing migration. After that, I have considered the ways to ensure the quality of the obtained data. Then I define the sample of my respondents and participants and their recruitment process in all three strands. Further, the tools used for the collection of data in all three strands of this study are described in detail. The ethical considerations and study limitations and delimitations conclude this chapter.

Chapter four (Results) describes the management of different type of data and their analysis. Then it presents all of the obtained results from all three strands in visual and/or written form.

The final, fifth chapter (Discussion) combines the data collected in all three strands of this mixed method study and discusses the results within the context of Czech nursing, Czech society in general as well as in the international context. In the beginning, I summarize the literature review and my own results, and then I begin to interpret the findings by first presenting a case study of a fictional Czech migrant nurse. Secondly, I use the nursing specific middle range theory on migration (Freeman et al., 2012a) as a lens to evaluate the different aspects of Czech nursing migration. A conclusion, with the implication for nursing practice and the nursing profession, as well as a recommendation for future research, closes the thesis.

2 Chapter - Literature review

2.1 Introduction to Chapter 2

This chapter reviews the main literature and documents related to the migration of general care nurses. I have begun with a description of how the relevant information resources were identified, assessed, stored and managed. Secondly, to demonstrate the current significance of the selected research topic and its context, I have briefly defined migration in general, as well as the extent and the character of migration to the European Union. Thirdly, I have narrowed my scope and I have described in much more detail the current specific issues related to the migration of health care professionals - the influencing factors, the factors which limit our understanding of this issue, and recently undertaken research activities. Fourthly, the complexities of nurses´ professional migration have been addressed in depth, concentrating on the latest conducted studies and statistics. After introducing the middle range theory on nursing migration, I have described the recent and current flows, the recently discovered experiences of migrating nurses, the obstacles they commonly encounter during their migration process, and the consequences of this process. The final section of the literature review is devoted to assessing the evidence concerning Central and Eastern European migrating nurses and specifically the very limited knowledge about the migration of Czech general care nurses. This approach allowed me to progress from a general overview to more and more specific topics, some of which need to be researched further.

2.2 Search strategy

The initial search for literature relevant to this study was conducted in May-July 2011 using the following databases: EBSCOhost Research Databases, CINAHL, ProQuest Nursing and Allied Health Source, Science Direct, and Medline. I used Remote Access to the QMU library, and I searched a Czech database and Google Scholar as well. I searched for documents in English and Czech language. The lists of references found in the retrieved studies (references within references) were searched as well, resulting in many relevant additional sources of

information. In order to concentrate on recent studies (less than five to seven years old), the search period was limited to resources published after the year 2004. Simultaneously, the selected period covered the moment when the Czech Republic joined the European Union in 2004.

The combinations of the following terms were searched for: “nurse migration”, “international migration of nurses”, “mobility”, “nursing”. Boolean operators were used in these searches. I found many studies describing different aspects of nursing migration mainly from the Philippines, India and Africa. I concluded this part of the literature search when the results of the retrieved studies started to repeat themselves, and I felt I had a sufficient amount of information on these groups of nurses. Consequently, three additional terms (“Central Europe”, “Eastern Europe”, “post-communist countries”) were added to search for articles describing nursing migration from Eastern and Central Europe in all databases, because until then I had only located a few articles related to this theme. However, these additional geographical terms in the search did not yield any other relevant results. In 2016, when the theme of Czech nurses being transformed by their migration became apparent in my research, I used the following key words to search the databases: “nurse”, “migration” and “transformation” or “changes.”

Considering the time span necessary for completion of this part time study (about six years), the literature search was later repeated in regular intervals in order to capture any new and relevant publications (2x in 2012 and 2013, 1x in 2014 and 2015). Indeed, some important results were published between the years 2011 and 2015 e.g. (Wismar et al., 2011b), (Freeman et al., 2012a), (Dywili et al., 2013), (Tjadens et al., 2013), (Schultz and Rijks, 2014), (Buchan et al., 2014a), (Moyce et al., 2015). For the later searches I used the new QMU search service Discovery, searching for the same terms but later publishing dates. I searched the e-Thesis (in 2013 and 2014) and EThOs (in early 2014) databases for an example of a recently and successfully defended UK PhD thesis in a nursing related field, using mixed research methods. The QMU eResearch database was explored in 2013 but this did not yield any new information.

Originally, I used Reference Manager to organize my literature, but I transferred to Refworks when it became available in QMU. Here, I struggled to fully exploit the functions of Refworks to manage my bibliography. In 2013 I learned how to work with the EndNote citation manager, and consequently I transferred all my resources from Refworks to EndNote and continued to use EndNote throughout the preparation of this thesis. I used the Harvard quotation system, which was recommended at QMU in 2010 when I started to search for relevant literature.

2.3 What is migration

The International Organization for Migration (IOM) deals with issues related to migration and migrants worldwide. This organization defines migration as:

> The movement of a person or a group of persons, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification (IOM, 2016).

Migrant is defined by IOM as:

> any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of:
>
> (1) the person's legal status;
>
> (2) whether the movement is voluntary or involuntary;
>
> (3) what the causes for the movement are; or
>
> (4) what the length of the stay is (IOM, 2016).

The researcher Solimano views international migration as a barometer informing us about the economic, political, social and other conditions in both, sending and receiving countries. Economic theories suggest that people migrate voluntarily mainly in the presence of a significant difference between the wages in both countries (Solimano, 2010). Generally speaking, most often citizens of low-income countries migrate to high-income countries, and a large part of these flows are of illegal migrants. Migrants from low-income countries are most likely those with a better education in the home country. Migrants from poorer countries often send remittances to the home country; this support seems to increase the use of educational and health care services in the home country (Hanson, 2010).

According to the United Nations, in 2013, there were about 232 million migrants around the globe, which is a 33% increase since 2000 (UNFPA, 2016).

2.4 Migration within the European Union

In order to place the migration of Czech nurses into a wider social context, I would like to briefly examine the current general migratory trends in Europe, including the migration of the Czech population.

According to the European Commission (2010), the citizens of the European Union (EU) countries value mobility and are free to settle anywhere within the EU, but 84% of them have not lived or worked in another country other than their own. The EU report (European Commission, 2010) states that about 17% of Europeans are tentatively thinking about working in a different state in the future, as compared to 11% of Czech citizens with similar plans. The citizens of the 12 EU member states[4] accessing in 2004 and 2007, including the Czech Republic, are more likely to migrate for economic reasons as compared to the citizens of the old EU states (European Commission, 2010). On 1 January 2014, there were about

[4]The Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia (EU8) accessed the EU on 1 May 2004 together with Cyprus and Malta. Bulgaria and Romania accessed the EU on 1 January 2007. Croatia accessed the EU the most recently on 1 July 2013 and it is not mentioned in this material.

33.5 million people living in the EU who had been born outside of the EU, which constitutes about 4% of the EU-28 population (Eurostat, 2016).

Massey divided the history of European migration into 5 phases; the first one being the period between 1900 to 1950, when Europe was primarily an emigration region. The second phase started after 1950 and was defined by importing laborers from more southern regions to Europe. This phase ended in 1973 with the onset of the economic recession. During the third phase, the previous economic migrants settled with their families permanently in Europe. The fourth phase started in 1985 and was characterized by the arrival of new asylum seekers from Eastern Europe, while the 2nd generation of the previous economic migrants entered the labor market. The fifth phase started in 1990 and was defined by free residents´ movement within the European Union (EU) and increased illegal migration to the EU (Massey, 1998). It is possible that we are currently witnessing a sixth phase, with an unprecedented inflow of migrants from North African and Middle East countries.

While many authors (see page 27) have commented on the insufficiency and poor reliability of data regarding the migration flows, some suggest that the official data for migration should be tripled to make a realistic estimate of, for instance, the emigration from Central and Eastern Europe after the political changes in late 1980 (Kaczmarczyk, 2006). Seasonal migration and cross-border emigration were popular in the post-communist countries (e.g. about 50,000 Czechs commuting to Germany as irregular migrants in early 1990). Based on the data from Great Britain, in 2006, 62% of the registered workers from EU 8 countries were from Poland (approximately 264,000 people), while only about 21,000 were Czech workers. Kaczmarczyk states, however, that highly skilled migration was much less intense - in 2005, 2,830 certificates were issued to Polish nurses who wished to migrate (the total workforce was 240,128 nurses registered in Poland), which amounts to 1.2 per cent of this professional group in Poland. The accession in 2004 did not bring on a mass migration from the accessing countries (Kaczmarczyk, 2006).

There has been only a limited amount of evidence describing the international migratory patterns of Czech highly skilled professionals, which is probably caused by the fact that the Czechs have a lower migration rate than the other EU 10 nationals in general (Vavreckova et

al., 2007). Another study by the same team (Vavreckova et al., 2006) stated that the migration of Czech skilled professionals is significantly influenced by the wage difference between the destination and source country. When the wages in the home country reach 75% of the wages in the host country, the costs of migration are higher than its benefits and the migration slows down. However, the opportunity for professional development abroad is also an important factor for this population.

The Czech Republic belongs to the group of states with low migrating potential (0.5 – 1.8 per cent) and low professional mobility (Vavreckova et al., 2006). The majority of Czech migrants reported that they prefer temporary working migration (lasting a few years) with an eventual return to the home state. 85% of the Czech population had no intentions to migrate (Vavreckova et al., 2006). This finding is similar to the one made by the European Commission (European Commission, 2010) mentioned earlier. Gender was not significant in predicting migration, unlike age – younger Czech people are more willing to migrate (Vavreckova et al., 2006). This age-related finding was also obtained in the MoHProf study (Schultz and Rijks, 2014). Also, the extent of Czech intra-national migration to seek work remains low. Additionally, 60% of migrants who worked abroad reported working abroad in other professions than in their own. Approximately 0.4% of the Czech population lived in the A15 countries in 2006, the typical destinations being the neighboring countries of Germany and Austria, as well as the United Kingdom (UK) (Vavreckova et al., 2006).

Around 1,400,000 of non-EU nationals immigrated every year to the EU between the years 2010 and 2013. These numbers do not include any asylum seekers or refugees (European Commission, 2015). The annual numbers of asylum seekers or refugees to the EU were between 200,000 and 300,000 between the years 2003-2012. There was a noticeable increase in 2013 and 2014 (over 400,000 and 600,000 respectively) (Sabbati et al., 2015).

Europe witnessed an unparalleled movement of people in 2015, when about one million asylum seekers came to the EU, which is almost double the amount from the previous year. The current asylum seekers come mainly from Syria, Iraq, Eritrea and other countries in the Middle East. Their exodus was triggered by the political instability and war conflicts in the Arab region. Their profiles and their motivation for migration were diverse (OECD, 2015a),

and the resources of the most popular EU destination states and capability of the society to absorb such large numbers of refugees were limited.

The key points explored in this section have related to intra-EU mobility, which is less intense than the migration of non-EU citizens into the EU. Even though not many studies on this topic have been published, it seems that the CR is a state with a low professional mobility.

2.5 Migration of health care professionals

The international migration of health care professionals has been increasing around the world, and this has multiple implications for the provision of health care services. Thus, it is an important topic, which will be now explored in more detail, including the reasons for bringing this topic to the political agenda, the possibilities of monitoring the migratory flows and recently undertaken research activities.

The European mobility of health professionals was defined by the PROMeTHEUS project as: *"*Any intentional change of country after graduation with the purpose and effect of delivering health-related services, including during training periods.*"* (Wismar et al., 2011b), (p. 14).

According to a recently performed concept analysis, a definition of nursing migration has not yet been delineated (Freeman et al., 2012a).

The international migration of doctors and nurses was first researched in systematic detail at a global level by Mejia in 1978, who, among other findings, determined that the total stock of nurses working abroad was lower than 5% and the main host countries were Canada, West Germany, the UK and the USA (Mejia, 1978).

The migration of health care professionals is viewed in a different light by different groups. On one hand, there are advocates for international mobility and the personal right to migration. They argue that not only does the migrating worker benefit (enhancement of career opportunities and salary), but also the sending country benefits from received

remittances and new skills of the (returning) health care workers. Naturally, the receiving country benefits from the increase in the workforce. On the other hand, critics of the impact of migration point out the consequences of migration for the poorest regions, where nobody plans to return (Troy et al., 2007), (Bach, 2008), because return migration is also not an easy step and has many different obstacles (inability to find employment in a home country, low wages, insufficient career prospects, disturbed family ties, etc.) (Haour-Knipe and Davies, 2008), (Buchan et al., 2014a).

Many authors agree that our understanding of health care professional migration is limited by the difficulties to collect detailed and reliable data about the migratory trends. These data are either not collected at all, or they are not comparable at the international level (Buchan et al., 2005),(Buchan and Perfilleva, 2006a), (Buchan, 2006b), (Kingma, 2006), (OECD, 2008), (Dussault et al., 2009). The most obvious inaccuracy is, for example, distinguishing a nurse registered in a certain country from a nurse who is actually practicing, or a foreign-born versus a foreign-educated nurse (Dumont and Zurn, 2007). The migration data are usually drawn either from the granted entry visa and work permits, or from the professional registers and qualification verification data, which are collected by the host or home country regulator[5] (Bach, 2008).

For example, 7% of nurses in Austria appear to be migrants, and a majority of them are from other EU countries, but the available data are not very transparent. What remains especially unclear is the composition of the Austrian nursing workforce caring for seniors in their homes (Biffl, 2006). However, in order to respond to societal changes appropriately, the policymakers should be able to continuously assess the migratory flows of health care professionals (Buchan et al., 2006a).

The migration of health care professionals has recently received great attention globally, mainly as a result of the emerging shortage of health care professionals (Aiken et al., 2004), (Buchan et al., 2006a), (OECD, 2010b), (Ognyanova et al., 2012), (Glinos, 2015), (OECD, 2015b). In 2008 the Green Paper on the European Workforce for Health was published in the

[5]However, this information often only indicates an intent to work abroad, rather than the fact that the person works in a given country.

EU to address at the political level the topic of a sufficient health care workforce in the times of an aging population and rising expectations. It is expected that this shortage will only worsen in the future, particularly because of the current demographic trends in the developed countries (European Commission, 2008). Later, two large EU funded projects (with the acronyms PROMeTHEUS and MoHProf) mapped the health care workforce mobility.

First, the Health PROMeTHEUS (Health Professional Mobility in Europe) project lasted from 2009 until 2012. It aimed at increasing our knowledge about the mobility of health care professionals within Europe and consequently at formulating recommendations for better health workforce management. Different types of countries (source, destination countries, EU15, EU12, non-EU countries[6]) were included in this project for analysis. The project explored the extent of European health care professionals´ mobility, the effect of the EU enlargement in 2004 and 2007, the motives of the migrants as well as the impact of this mobility. Dissatisfaction with working conditions, salaries and social recognition were among the motivators for migration; the migration of health care professionals following the EU enlargement was smaller than expected (Wismar et al., 2011b), (Buchan et al., 2014a).

Second, the general objective of the MoHProf (Mobility of Health Professionals) project was to research the current trends in the mobility of health professionals to, from and within the EU, including their return and circular migration. Twenty-five large sending and receiving countries[7] from around the world were involved in this project. The results of this project demonstrate the economic motivation of migrants, and show that hundreds of thousands of health care professionals are currently working in destination countries below their qualification level, because their credentials were not recognized. Migrating nurses often work in lower positions than that of their qualification, because language requirements are less strict for nurses working as aides. Malpractice cases of recruiting agencies, which are not regulated, were reported. In conclusion, the authors call for more qualitative research on migrant health workers' plans, profiles, motives, channels of migration (recruiting agencies

[6] Austria, Belgium, Finland, France, Germany, Italy, Spain, the UK, Estonia, Hungary, Lithuania, Poland, Romania, Slovakia, Slovenia, Turkey, Serbia

[7] Austria, Germany, Ireland, France, Netherland, Portugal, Sweden, the UK, India, Philippines, Angola, Egypt, Ghana, Morocco, Kenya, South Africa, Lithuania, Poland, Romania, Bulgaria, Ukraine, Russia, the USA, Canada, Australia.

and their role), tracking graduates, and analyzing experiences of employment abroad; and they drew the following key recommendations from the MoHProf project:

- Be self-sufficient in the production of health care workers
- Reduce dropout rates
- Plan human resources in health care at EU and country level
- Monitor the healthcare workforce
- Build sustainable health care systems (Tjadens et al., 2013), (Schultz and Rijks, 2014).

Buchan and Perfilleva demonstrated earlier the migration of nurses and physicians in five case studies of selected countries in the European region. The authors offer an overview of the push and pull factors[8], and they describe the typology of migrants, permanent and temporary migration and official versus unofficial (undocumented) migration. Even though international migration is the most visible, migration out of the profession or from rural areas to more developed areas often precedes international migration. Migration is a very dynamic process, which means that a previously sending country can quickly become a receiving country and vice versa, as witnessed in the case of Ireland (Buchan and Perfilleva, 2006a) or Portugal (Ribeiro et al., 2014).

Return migration[9] and circular migration[10] seem to be more commonly mentioned within the last 20-30 years, and a possible explanation might be the fact that transportation has become more affordable (Kingma, 2008), (Haour-Knipe and Davies, 2008). Affordable and new communication means also contribute to increased return and circular migration (Kingma, 2001), (Haour-Knipe and Davies, 2008).

[8] The pull factors (which "pull" the migrant to a certain country) include high remuneration, work benefits, decent work conditions, full-time work, a safe environment, sufficient resources within the health care system, career opportunities, educational opportunities, economic and political stability, presence of family or friends, shared language, similar education, historical ties between the source and destination country, and more recently recruitment activities and the global shortage of health care workers itself. Push factors (which "push" the migrant out of a country) represent the opposites of pull factors.

[9] Return migration is defined as the return of persons to their country of citizenship after having been international migrants (whether short-term or long- term) in another country and who are intending to stay in their own country for at least a year (United Nations, 1998)

[10] The term "circular migration" describes the situation when the migrant returns home after a certain period abroad, but later migrates again.

The MoHProf project showed that the Internet is greatly facilitating migration (Schultz and Rijks, 2014). Social networks abroad are important for stimulating migration, and currently, recruitment activities are directly facilitating migration (Kingma, 2001), (Bach, 2008), (Schultz and Rijks, 2014).

The typical pull factors, such as geographical proximity, similar climate and language, were found in the MoHProf project as positively influencing the decision to migrate. Political stability and professional development opportunities are called “stick” factors (the decision whether to move outside of a home country is more related to personal and social aspects of life then push and pull). Typical “stay” factors (reasons for not leaving the host country) are the presence of family, friends, and networks in the receiving country and the need to send home remittances (Tjadens et al., 2013), (Schultz and Rijks, 2014).

Further, Buchan and Perfilleva pointed out the non-linear and often very individual migration path of health care professionals (migrating to one country, returning home only to migrate again or to commute regularly to a neighboring country to work) (Buchan and Perfilleva, 2006a). Similarly, various modes of migration were discovered in the recently completed MoHProf project - commuting, temporary, long term, permanent migration, country hopping (e.g. migrating first to the UK, then to the Middle East, later to Canada). Doctors seem to migrate more often for professional development, nurses for better salaries, and workers younger than 40 years of age tend to migrate more. Networks and family do influence migration, e.g. migrants return because of older parents. Following a spouse is a common mode of migration. Nurses tend to return home more often than doctors (Schultz and Rijks, 2014).

The Organization for Economic Cooperation and Development (OECD) published a policy brief in 2010 commenting on the increasing rate of international migration of doctors and nurses, and on its negative versus positive consequences. The authors described the effect of the economic recession on migration, the return of workers from other professions back to the rather stable employment in health care as well as the aging of the health care workforce. They also used the typical push and pull factors to explain the reasons for migration, and stated that international migration itself is not the main cause of the

shortages in developing countries. They suggested that a sustainable approach is to train enough health care workers in the developed countries, as well as to improve their retention and productivity. Similarly, source countries should improve their retention by improving working conditions and career development prospects. Both types of countries should cooperate in bilateral agreements promoting temporary migration (ICN, 2007b), (OECD, 2010b), collecting data on the migratory flows and adopting the WHO Code of practice for the international recruitment of health personnel (OECD, 2010b).

Currently, the migration of health care professionals continues to be a globally "hot" topic. While there are still inaccuracies in monitoring the migratory flows, important evidence was identified from the recently conducted studies and projects. Motives for migration and possible measures to manage its negative consequences were described in these studies, and are discussed in the next sections.

2.5.1 Policies influencing migration

National and international policies and approaches can significantly influence the migration of health care professionals. Legal regulations as well as voluntary recommendations made by international organization will be mentioned in this section.

Bach stresses the importance of state policies (Bach, 2007). The adoption of the Directive 2005/36/EC on the recognition of professional qualification is an example of an attempt to influence migration on a political level, and the Directive[11] significantly shapes the EU migration of nurses (among other health care professionals) (European Parliament, 2005).

The voluntary WHO Global code of practice on the ethical recruitment of health care professionals, published in 2010, is another example of such policy. It contains guidance for international recruitment which should equitably strengthen the involved health care systems, assures the personal right of migration and provides recommendations for sustainability in the production of health care workers, as well as for the collection of data about the workforce (WHO, 2010b).

[11]The Directive 2005/36/EC on the recognition of professional qualification was amended in November 2013 as DIRECTIVE 2013/55/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL on the recognition of professional qualifications and Regulation (EU) No 1024/2012 on administrative cooperation through the Internal Market Information System.

Glinos refers to the WHO Global code, which all EU countries have signed and should follow externally (when recruiting from non-EU countries). However, in the case of intra-EU mobility of health care workers, it seems that the poorer EU countries face more often the negative consequences of this migration, while the richer countries benefit more from free mobility. Thus, the ethical message of the Code is not fully observed, while such mobility is still completely legal (Glinos, 2015). Moreover, in the UK, for example, the Code is observed only by state owned facilities and not by the private sector (Schultz and Rijks, 2014).

Skills which are not used in a source country can be efficiently used in another EU country in the case of unemployment of health care workers. Thus, mobility can enhance equity, because all health care professionals have a chance to receive fair rewards. On the other hand, considering that the qualifying education of doctors and nurses is mainly publicly funded in the EU countries, their mobility causes a less transparent distribution of these funds. Similarly, the expert skills of the migrating nurses are not always used efficiently in the destination country (e.g. Estonian emergency nurses working in nursing homes in Norway), and the costly integration training in the destination country health care system is not always performed, thus resulting in a less efficient adaptation. When destination countries cover their needs for health care professionals from abroad, they are not forced to solve the underlying problems in their own system (e.g. unsatisfactory working conditions and salaries) (Glinos, 2015), and the vicious, and ethically problematic, circle of needing to search for large numbers of smart nurses from other under-resourced countries continues.

As shown in Figure 1, the ratios of practicing nurses in some of the source countries are much lower than those in the destination countries. Portugal had 5.7 nurses per 1000 population, Romania 5.2 nurses per 1000 population; the average in the EU was 7.9 nurses. For comparison, the Czech Republic had 8.1 nurses per 1000 population in 2010 (OECD, 2013). Thus, mobility of nurses from such source countries to the typical destinations countries poses an ethical dilemma. Even though the migrating nurse might eventually improve her/his personal situation (financially, career enhancement, living conditions, job satisfaction, etc.), the source country will definitely lose a qualified professional in whom it invested scarce resources during her/his education.

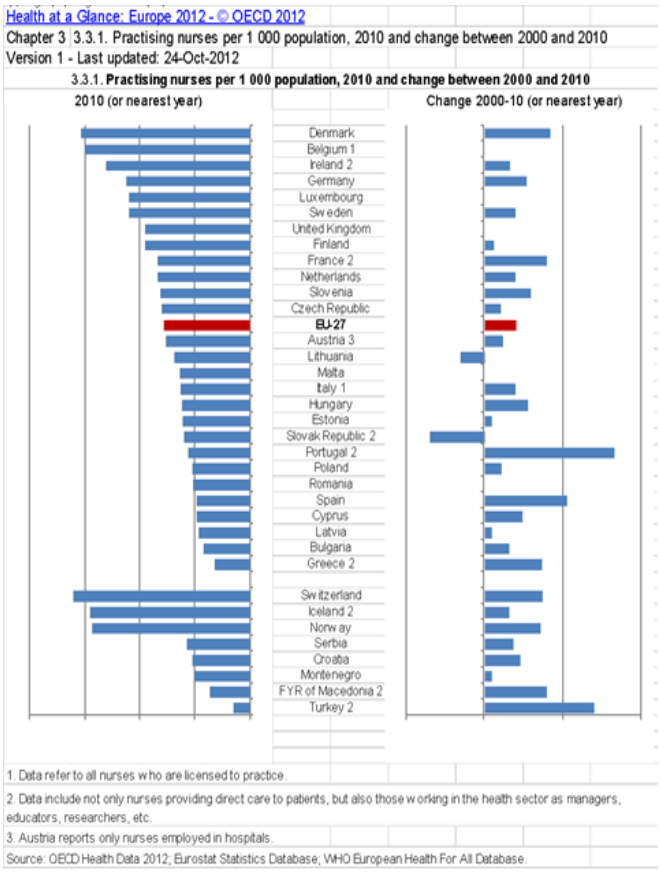


Figure 1.[12] Number of practicing nurses per 1000 population (OECD, 2013).

Apart from general policy interventions which try to influence the migration of health care workers, the most authoritative organization of nurses, the International Council of Nurses (ICN), expressed their opinion on nursing migration and recruitment in two position statements in 2007, in which they recognized the right of each nurse to migrate, acknowledged the positive and negative consequences of migration, condemned unethical and exploitative recruitment, and described principles of migration. Among these principles were: a proper orientation period and supervision, the self-sustainability of countries, a safe work environment, regulation of recruitment, and freedom from discrimination (ICN, 2007b). The second statement was related to the retention and migration of nurses, where ICN stressed the need to collect data on the workforce and pay attention to nurses working conditions and environment. Here, the ICN also warns nurses about the possible problems with the recognition of their qualification abroad (ICN, 2007a).

[12] The ratio of nurses per 1000 population has increased in Portugal since 2010 to 6.1 nurses in 2015, the data for Romania were not available in the 2015 edition of Health at Glance (OECD, 2015c).

Considering the high reliance of western society on its (health) care services, as well as the current shortage of health care professionals and the demographic trends, we should be preparing more care workers, health care workers, and health care professionals, while at the same time seriously improving the image of nursing and even more so the working conditions in (health) care facilities (Bach, 2008), (Dussault et al., 2009), (OECD, 2010b). It has been known for more than a decade that there are high numbers of non-practicing nurses in each country and very often their reason for their workforce withdrawal are unsatisfactory working conditions (Kingma, 2006).

Buchan and Campbell describe the World Health Assembly decision (May 2013) to renew the interest in the health workforce, which was somewhat reduced when the global financial crisis in 2008 impacted the budgets available for the health care workforce. The major issues that should be solved now are the following: the nursing shortage, the improvement of retention, issues of attrition and out migration, the better use of the skills of health care professionals, their new roles, effective incentives as well as appropriate working conditions (Buchan and Campbell, 2013).

As shown in a study recently funded by the EU, the retention of experienced staff is high on the political debate in many countries, together with attempts to recruit more new health care professionals (Kroezen et al., 2015). For instance, the USA attempted to stimulate the attractiveness of the nursing profession by offering loan forgiveness programs for nurses, as well as specialist education and the improvement of working conditions (Schultz and Rijks, 2014). When Poland increased the salaries of health care professionals in 2007, it slowed down migration and even caused return migration (Wismar et al., 2011b).

Most recently, experts have highlighted the importance of systematic health workforce governance, mainly as a thorough planning, managing and preparing of the workforce. The governance approaches seem to differ from country to country, but there is an opportunity to learn from each other's successful strategies (Kuhlmann et al., 2015).

This section has explored the role of policies implemented locally, nationally and internationally that can influence the migration of health care workers. Apart from the options mentioned above (workforce monitoring, sustainable production, improved working

conditions), there are other policy interventions which have been tested in different countries (bilateral agreements, temporary staff exchanges, intentional training health care professionals for export, and even less commonly, compensation for source countries) (Buchan and Perfilleva, 2006a). Now it is important to use these policy interventions wisely and ethically in order to provide for a stable health care workforce and care workforce, and thus for a stable delivery of health care services.

2.6 Migration, return migration and circular migration of nurses

This section examines the categories of migrating nurses, theories related to nursing migration, flows of migrating nurses as well as their experiences as migrants, and the consequences of migration.

The Canadian researcher Freeman prepared a case study on nursing migration. An important conclusion from this study was that nurse researchers should be more involved in conducting studies on nurse migration because they can contribute a different and valuable perspective on the nurse migration topic, and on its findings, interpretation and methodology (Freeman et al., 2012b).

2.6.1 Categories of migrating nurses

A comprehensive summary of nursing migration was written by Kingma in 2006, who herself was a nurse and a nurse migrant. In her book she defined different categories of migrant nurses:

- economic migrant
- quality of life migrant
- career migrant
- partner migrant (follows a partner abroad)
- adventure migrant (uses nursing qualification to experience new things)
- survival migrant (escaping war or unstable political conditions)
- holiday migrant (usually younger person who starts working and travels at the same

time)

- student migrant
- contract migrant

Livelihood migrants, career oriented migrants, backpackers, commuters, undocumented migrants and return migrants are the types of migrants suggested in the results of the PROMeTHEUS project (Buchan et al., 2014a).

Kingma has also described the migration path typical for nurses: first, the nurses migrate intra-nationally (from a rural area to a city), then to the private health care sector, then completely out of health care, and then international migration occurs. She mentions the issue of workplace violence or discrimination experienced by migrating nurses. While diversity in the workplace can improve care, it can also lead to discriminatory practices (Kingma, 2006).

Some other authors question the current trend of too much diversity among the staff in health care facilities, and whether it can have implications for patient safety (Habermann and Stagge, 2010), (Neff et al., 2013).

Just as in the general population of migrants, the increased migration of nurses clearly points to deeper and serious problems in the home country (most often low salaries, poor working conditions, heavy workloads and lack of career opportunities) (ICN, 2007a), (Bach, 2008). Some non-European countries tried to limit the degree of nursing migration by leveling fines or charging the costs of the provided education if a nurse decided to migrate. Some even changed the length of the curriculum so that the graduates are not as attractive to foreign employers (Bach, 2008). However, creating a regulatory or financial barrier to leave a country is not very productive (Schultz and Rijks, 2014), does not remove the existing push factors, and opposes the right to free movement of individuals (Kingma, 2001).

Kingma stated already in 2006 that in order for migration to take place, strong push factors need to be present, irrespective of the pull factors (Kingma, 2006). Similarly, a sociologist Saskia Sassen commented on the current migration to the EU, stating that "…migration is hard work…" which could be avoided if the conditions in the home country were more

favorable (Sassen, 2016). According to Kingma, if nurses were to be offered decent wages and conditions, the push factors would be too weak to initiate migration (Kingma, 2006). The exceptions to this rule are probably those of adventure migration and maybe career migration, when some nurses from developed countries migrate to other developed or developing countries in order to experience something new or boost their career.

Redfoot has identified pull factors affecting the international migration of nurses to western long-term care facilities. First, one pull factor is the demand caused by the aging of the Western population. A second pull factor is characterized by ethnicity, where "women of color" take up positions which the local workers are, as mentioned earlier, unwilling to take because of poor working conditions. At the same time, however, the credentialing process creates obstacles for these workers to obtain an RN position. Colonial ties and a common history are other pull factors, together with recruitment, which is affected by unofficial channels and contacts (Redfoot and Houser, 2008).

2.6.2 Theories on nursing migration

Until recently there has not been any theory specific to the migration of nurses, therefore general theories on migration were used to explain the migration of nurses. The theory of push and pull factors is most often used when describing this phenomenon (Kingma, 2006). Massey lists the basic migration theories (Massey, 1998), but none of them seem to be sufficient to completely cover the specifics of nurses' migration around the world. A migration theory called "New economics of migration" stresses the role of household and extended family in the decision to migrate from developing countries (Massey, 1998). This can be demonstrated by studies, which found that many of the migrating nurses from developing countries were encouraged by their families to become nurses in order to find work abroad (Troy et al., 2007), (Alonso-Garbayo and Maben, 2009), (Humphries et al., 2009a). In contrast to this, Bach believes that the role of households is less prominent in the migration of skilled health care professionals (Bach, 2007). This contradiction is probably related to the only very recent understanding of nursing being a skilled profession.

The neoclassical theory of migration emphasizes the higher monetary return of migration as the main motivator. All of the nurses in Troy´s study were sending remittances to their home country (Troy et al., 2007), and 87% of the respondents in Ireland sent remittances regularly,

even though it was difficult to sustain it during the economic recession. The reason was a high dependency of their families in home countries (often parents) on this mode of income (Humphries et al., 2009a). In a Nursing and Midwifery Council (NMC) survey of randomly selected internationally educated nurses working in London, 57% of the respondents claimed to send remittances regularly to their country, but this question was more often left blank (Buchan et al., 2006c). The economic reason was identified to be the main push factor in other studies (Thomas, 2006), (Jose, 2008), (Wismar et al., 2011b), (Tjadens et al., 2013), including a content analysis of 17 scientific articles on nurses' migration; while professional advancement and lifestyle opportunities were often viewed as additional benefits (Dywili et al., 2013). On the other hand, German nurses practicing in Germany identified other leading push factors which were important in their context (poor working environment with emotional exhaustion, low recognition, poor advanced training prospects, lack of nurse-physician collaboration, staff shortage, low decision making power) – here, the economic factor ranked second to last (Zander et al., 2013).

In 2011, Freeman and her colleagues suggested a middle range theory specific to nurse migration:

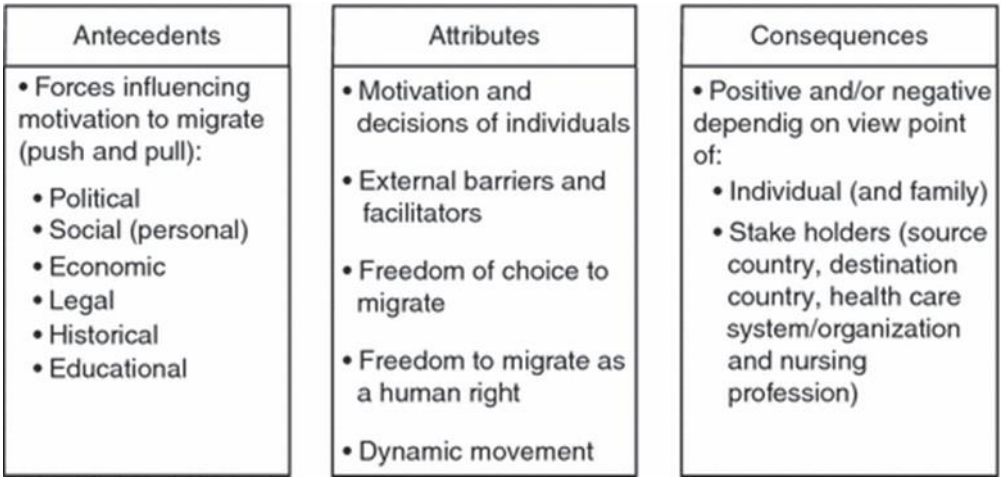


Figure 2. Concept of nurse migration: antecedents, attributes and consequences (Freeman et al., 2012a).

The attributes of migration (Fig. 2) are preceded by forces influencing the motivation to migrate (the push and pull factors divided into six groups of so called antecedents).

Nowadays, an important pull factor is the global shortage of nurses itself and the related recruitment activities. A common history and language is another facilitating factor. The theory further identifies positive and negative consequences of migration for the different players in the migratory process (the migrating nurse and her/his family, the source and the destination country, the health care institutions, the nursing profession in general, etc.) (Freeman et al., 2012a). This theory seems to offer a better understanding of the nursing migration phenomenon by providing a complex and wide picture without a restrictive focus on one factor (e.g. economic). The theory now needs to be tested and developed further.

The theory of transformative learning is currently not connected with any migration theory. Illeris himself does not specifically mention that migration (of nurses) can be seen from the perspective of transformative learning, but this theory seems to closely describe the changes in identity of nursing migrants and their fundamental transformation witnessed during and after migration. Interestingly, Illeris mentions nursing education as an example of transformative learning.

Illeris defines transformative learning as that learning which changes the identity[13] of the learner (Illeris, 2013).

> Transformative learning means gaining qualitatively new structure or capacity within the learner, while the old knowledge is changed. Many things can be transformed by learning, apart from cognitive issues; also the self, the identity and consciousness can be changed as well. (Illeris, 2013) (p. 5).

[13]In the second part of the 20th century, after the rapid economic changes of the 1960s, the western world experienced de-traditionalization, when many norms, regulations and traditions were abandoned. The previous seemingly permanent traditions were no longer binding, and any individual could suddenly choose how she/he prefered to spend her/his life; however, this person still had to deal with the consequences of her/his choices. Bauman (cited in Illeris, p. 5) states that we have to create our own identity in a time of liquid modernity, while in the past, identity was mostly provided by our environment. Now our identity is a lifetime project. When we finally achieve our goal and become who we want to be (creating our own identity), we are obliged to be that person, and simultaneously we are not free to be whoever we want anymore.

Identity is created, developed, and changed through learning. There are many types of identity (e.g. personal, sexual, national, religious, social, professional). Illeris quotes Mezirow´s and Taylor´s core elements and principles of transformative learning which need to be fulfilled so that transformative learning can take place. Among the core elements are individual experience (both previous, and of the current transformative learning), critical reflection of the transformation, dialogue about the transformation, holistic orientation (changes are facilitated by see-feel-change more than analyze-think-change cascade), and awareness of the context in which the change takes place.

Transformative learning requires a learner-centered approach. Among the principles of transformative learning are purposefulness, which allows the student to discover on his own, confronting power and using differences, putting the learner under stress (facing dilemmas, feeling insecure, going beyond the habitual) and fostering reflection (Illeris, 2013). As demonstrated in Chapter 2.6.4., all of the above mentioned principles and elements seem to be present during the professional migration of nurses.

An article about migrating Jordanian nurses explicitly described the transformation experienced by these nurses after migration. The participants of this qualitative study felt transformed personally (they perceived increased availability of professional opportunities, as well as an increase in self-confidence). Professionally they welcomed the established team work in the destination country, holistic approach to care and clear, evidence-based nursing guidelines and protocols which shaped their professional behavior and allowed them to recognize incorrect practices (Al-Hamdan et al., 2015).

Magnusdottir described in her phenomenological study on internationally educated nurses in Iceland their transformation/growth, which was facilitated by overcoming strangeness and communication barriers (Magnusdottir, 2005). Other studies often describe changes of migrating nurses, even though they do not go into the details of this transformation (Palese et al., 2008), (Jose, 2008), (Bratinkova 2011), (Newton et al., 2012), (Bludau, 2012).

2.6.3 Migratory flows of nurses

As mentioned earlier, a comprehensive monitoring of the movement of nurses across borders has many deficiencies, but it is extremely important for the management of the workforce. It can reveal interesting migratory trends which need to be acted upon.

The global share of foreign-born nurses grew from 11% to 14.5% between the years 2002 and 2012 years, which imitates the increased trend in migration of skilled workers. Switzerland, New Zealand, Australia and the UK have a nursing workforce consisting of more than 10% of foreign trained nurses. The percentage of foreign-born nurses in the Czech Republic seems to be low, at 1.6%, while the number of foreign trained nurses in the CR was not included in the study (OECD, 2015b). After 2008, the migration from countries endangered by the intense out-flow of nurses was slowed down by the economic crisis. Migration from EU10 to EU15 decreased by 50% from 2008 to 2009, due to the economic recession. Even though the authors do not provide any further details and the real numbers might be smaller, the Czech Republic supposedly had the biggest relative reduction in flows during this time (Schultz and Rijks, 2014). Fundamental changes in the patterns of nurse migration to some traditional destination countries during the economic crisis are described in other articles as well (Buchan and Campbell, 2013).

When comparing the migration of nurses from the developing world with the mobility of nurses within the EU countries, previous studies have suggested that intra-EU migration is at a low level, again copying the general mobility of citizens within the EU (Aiken et al., 2004), (Bach, 2007). At the same time, a more recent EU assessment suggests that EU health care professionals are nevertheless the most mobile professional group in the EU, and that nurses have the second highest rate of mobility when compared with the other professions included in the health care professionals group. The European Commission reported that between the years 2007-2011, about 15,200 EU nurses were granted an automatic recognition of their education (European Commission, 2011).

The stock of doctors and dentists from the new EU-12 member states in the old EU-15 member states has more than doubled since the 2004 and 2007 enlargements. The same data for nurses are extremely limited, but show only a slight increase. Around 1-2% of all EU nurses worked in an EU member state which was not their own. However, large numbers of

irregularly employed nurses working in the home-based, long-term care sector are not included in this number, and the UK, a major destination country, was not included in this study at all (Ognyanova et al., 2012). A quantitative study from the Netherlands found that the migration of EU nurses to the Netherlands was rather low (0.5% of the total workforce); but these data were collected before the EU-12 countries officially accessed the EU (de Veer et al., 2004).

The low absolute numbers of nursing migrants from Eastern Europe were somewhat surprising - the experts predicted a strong flow of citizens to the old EU states after the EU enlargement in 2004 because of the wage disparities in the health care sector between the old EU countries and the EU-12 countries (Vavreckova et al., 2006), (Aiken et al., 2004). This did not occur to the predicted extent. The annual migration from EU12 countries was estimated to be around 3% of the domestic workforce, which was probably influenced by the market restrictions in some destination countries and by implemented improvements in source countries (Ognyanova et al., 2012).

The European country with the biggest inflows of nurses, the UK, experienced fundamental changes in its recruitment approach when it implemented policy to restrict active recruitment from overseas[14] destinations and open its market fully to nurses from Europe. However, British health care managers were uncertain as to what to expect from Central and Eastern European nurses after they had had experience with overseas nurses. They had doubts about the Eastern European nurses' skills, commitment and language abilities (Bach, 2010). Similarly, Irish health care managers also preferred overseas nurses for identical reasons (Schultz and Rijks, 2014).

In reality, between the years 1989-2008, the entrance of overseas nurses into the UK register fluctuated from 2,000 new nurses in 1989 to 14,000 nurses in 2004, and then back down to 2,300 nurses in 2008. In line with the reported smaller flows from Eastern Europe, the number of EU nurses on the UK register increased from less than 1,000 nurses to only 2,000 nurses during the same period (Young, 2011). Bach believes that if this trend prevails, it might

[14] The term "overseas" refers to the typical source countries and typical migrants from geographically distant countries such as the Filippines, India and African countries.

probably necessitate another wave of migration from overseas (Bach, 2010). Between the years 2008-2010, the annual flow of internationally educated nurses to the UK did not exceed 2000 people; the majority of them were from the EU. After the year 2010, the number increased up to 4000 incoming internationally educated nurses in 2012, again with the majority being from EU countries (Romania, Portugal, Spain and Ireland). There was an interesting gradual decline in the numbers of incoming Polish nurses in these years (Buchan and Seccombe, 2012).

The flow of nurses that migrate, but work abroad in jobs and professions other than as nurses responsible for general care is very difficult to estimate, because these numbers are not expressed in any official statistics (Buchan and Aiken, 2008a), (Haour-Knipe and Davies, 2008). If these nurses stay out of the nursing profession permanently, it is considered to be brain wasting, a situation where the skills of the person are not used efficiently (Kingma, 2006).

2.6.4 Experiences of migrating nurses

This section has explored an important topic of how the migrating nurses perceive different aspects of their migration. Before the year 2008, the personal experiences of migrating nurses were not explored as often as was the efficacy and ethics of migration (Buchan et al., 2005), (Bach, 2008). Within the last decade, there has been a wealth of research mapping the experiences of migrating nurses and the aspects of a successful adaptation period for migrating nurses. Thus, Kingma´s complaint from 2001 - that some areas of nursing migration are under-researched (Kingma, 2001) - is not completely valid anymore.

Overwhelmingly negative and excessively difficult beginnings in the most popular destination country were described by the participants in Jose´s phenomenological study, when migrating nurses realized that migrating for work to the USA was much harder than they had imagined it would be. They felt that there was nobody to help them, and no orientation to the issues they struggled with was provided (understanding slang, understanding the health care system, using technologies, coping with cultural diversity) and they were demotivated by the fact that their native colleagues viewed them as incompetent. These feelings eventually changed when the nurses adapted to their new environment (Jose, 2008). Similarly, Kingma suggested that the first two years of migration are the most difficult ones (Kingma, 2006).

Other authors suggested that the process of integrating an internationally educated nurse[15] into a host country nursing system can span from 12 months to 10 years (Yi and Jezewski, 2000).

Jose created six themes from her in-depth interviews with migrating nurses. These themes were chronologically ordered and named: *Dreams of a better life, Difficulties of the journey, A shocking reality, Rising above the challenges, Feeling and doing better, and Ready to help others* (Jose, 2008). The above-mentioned themes are very similar to the five themes later developed by Newton from a comprehensive review of the recent literature on nursing migration *(Reasons for and challenges with migration, Cultural displacement, Credentialing problems and deskilling, Discrimination and Successful strategies for transition)* (Newton et al., 2012). Both sets of themes manifest a deep insight into the world of migrant nurses and they offer interesting information about the transformative path of the migrating nurse.

Kawi and Xu, in their integrative review, explored facilitators and barriers to the adjustment of migrating nurses. According to the authors, the facilitators of adjustment are: being hardworking and persistent, being a perfectionist (the wish to prove that she/he is a "good" nurse), getting support from their friends and learning to be assertive (Kawi and Xu, 2009). The barriers were similar to those mentioned by Moyce in a later study (the communication barrier, the differences in nursing practice, presence of serious discrimination and racism, the lack of support for the newly arrived nurses, and insufficient and unspecific orientation). Also, the solutions suggested by Kawi and Xu seem to be similar to Moyce´s, which could result from the fact that the two literature reviews partly overlapped (Moyce et al., 2015).

We are now aware that the credentialing procedures are demanding and lengthy before even migrating; once in the destination country, migrating nurses typically struggle with the following: communicating in the foreign language, learning different approaches to nursing, understanding the autonomy of patients and sometimes with discrimination.

[15]The term internationally educated nurses (IENs) was selected among the many terms currently used (e. g. overseas nurses, foreign educated nurses, foreign trained nurses, foreign nurse) (as evidenced in the insightful concept analysis by Freeman et al. (2012a). This term seems to appropriately, and without a negative connotation, characterize nurses that were educated in one country and are/were practicing the nursing profession in another country.

Communication

The most important problem reported by migrating nurses in many studies was the limited communication ability due to the language barrier which caused the nurse to feel "like an outsider" (Magnusdottir, 2005), (Tregunno et al., 2009), (Newton et al., 2012). Adequate language skills in the nursing profession go beyond a mere proficiency in the language; appropriately using and understanding voice tone, stressing certain parts of a word, using silence, gestures, getting jokes - that all requires advanced knowledge of the language and of sociocultural context (Tregunno et al., 2009), (Blythe et al., 2009). In the urgent, global need for nurses in destination countries, only minor attention was paid to the deeper-lying issues of cultural adaptation (Buchan, 2008b), (Habermann and Stagge, 2010). Further, colloquial expressions, medical abbreviations and telephone interactions were difficult for the nurses migrating to the USA (Davis and Nichols, 2002). Even nurses who successfully passed the licensing examination in Canada had not achieved basic proficiency in the English language, and this has obvious implications for safe care (Tregunno et al., 2009).

Similarly, the language barrier was bigger than expected for European nurses migrating to Iceland. Even after the nurses could hold a basic communication in Icelandic, any deeper communication was not as accurate as they would want it to be, which caused them serious stress. As above, telephone communication also caused fear, due to the lack of nonverbal cues to enhance understanding (Magnusdottir, 2005). The nurses from the Philippines and India working in Ireland, who participated in Troy´s study, did not have a strong desire to integrate into the culture of the host country, preferred to retain their culture in spite of the fact that they often did not plan to return to home country. They also reported communication difficulties on their arrival (Troy et al., 2007). The perioperative nurses migrating from undisclosed countries to practice in Ireland also reported language problems, as well as problems being sufficiently assertive (Cummins, 2009).

Migrating nurses who did not speak the local language well experienced barriers to professional advancement and worked more often in the stigmatized geriatric care (Kingma, 2006). However, from the perspective of patients´ safety, a nurse needs to be very proficient in the local language, especially in a fast-paced hospital environment.

Differences in nursing practice

The different approach to nursing in the destination country was another reported obstacle. In a qualitative study, Tregunno interviewed 30 randomly selected internationally educated nurses working in the Ontario region in Canada, with the goal of exploring barriers and challenges to a smooth transition into the new workforce. Two participants came from Central and Eastern Europe (CEE). While twenty-nine participants stated that they migrated to find a better quality of life, all of the nurses described the nursing practices in the host country as different from those in their home country. The biggest identified differences were listed as: carrying out more responsibilities and fully respecting clients' autonomy (Tregunno et al., 2009).

Similar results were found by Adhikari when researching Nepali nurses practicing in the UK (Adhikari, 2013), as well as in a quantitative study with 113 participants, where 49% of the migrant nurses working in perioperative settings in Ireland found the work practices different from those in their home country (Cummins, 2009). Also, the internationally educated nurses in an Australian qualitative study were reported to be surprised that they were expected to know about all of the specialized health services, that a holistic and patient-centered care was being practiced and that clients were involved in their own care. They had difficulties with complex discharge planning, time management, making priorities and negotiating with other team members (Smith et al., 2011). Knowledge of the system, and especially of policies related to confidentiality and documentation, and working with technologies and modern drugs, a fast work tempo and practicing autonomously in the destination country were other differences in nursing practice that hampered a quick and smooth integration of migrating nurses (Newton et al., 2012). This issue was generally highly relevant, considering that before 2004, about 5.1% of the total nursing workforce in the USA had been internationally educated, but by 2008 it was already 8.1% (U.S. Department of Health and Human Services, 2010).

One qualitative study explored the challenges that influence a smooth transition of internationally educated nurses into the US nursing system. Twenty-one nurses and ten nurse managers were interviewed. An interesting detail is that even though the migrating nurses

were from seven different countries, their nursing training was provided in English. As in previously mentioned studies, the theme of different nursing practice in the host country occurred, specifically regarding nurse autonomy, responsibility for physical assessment, and the use of technologies. Spousal support and spiritual support were strategies for easing the transition during the orientation period (Sherman and Eggenberger, 2008). A special orientation/adaptation period for the migrating nurses is considered to be highly beneficial for everybody and necessary for a provision of safe care (Buchan and Perfilleva, 2006a). Over 90% of the respondents in the Irish study on perioperative nurses found the preceptor and the orientation programs valuable for their integration. Eighty percent of the respondents felt that they were given sufficient time (6 weeks) of adaptation and support to achieve competence (Cummins, 2009).

Discrimination

Recently some studies reported discriminatory practices in the destination countries and even racism (Tregunno et al., 2009), (Cuban, 2010), (Newton et al., 2012), (Moyce et al., 2015). Discriminatory practices were an important issue in the study conducted on internationally educated nurses working in Saudi Arabia, as such practices (not surprisingly) greatly contributed to work dissatisfaction of the studied nurses. The discrimination was financial, personal and involved limited use of certain benefits such as higher standard living arrangements (Mitchell, 2009).

A qualitative study from England described the brain wasting of qualified oversees nurses in England. These migrating nurses felt exploited by the system, where never-ending additional charges for their “further professional education” were required by the manipulative recruiting agencies, but career advancement opportunities were not available. If the nurses finally managed to have their qualification recognized and were promoted from previous auxiliary posts, which often combined caring and domestic work, their salary increased minimally. For that reason they often kept both positions and alternated working as, for instance, a health care assistant and a RN. This study further demonstrates the strategies which the migrating nurses used to cope with their situation (Cuban, 2010).

Apart from describing discriminatory practices at the hand of colleagues, auxiliary personnel and patients, Sherman also suggests a few strategies to facilitate a smoother transition to the new nursing system. For example, the possibility of the nurse to choose in which area of nursing she/he wants to practice[16], to attend accent reduction classes, and to use an experienced nurse migrant for helping a new nurse migrant with her/his transition. The authors present a recommendation for a curriculum for internationally educated nurses in their paper, which covers fundamental clinical areas of nursing practice, seminars on American idioms, culture, and critical thinking, practicing nursing skills, simulating scenarios such as physical assessment, and a seminar on the role of nurses in the USA, including legal regulation (Sherman and Eggenberger, 2008), (Kawi and Xu, 2009), as well as lessons on local cultural and work values (Davis and Nichols, 2002), (Kingma, 2006), (Bieski, 2007). Additionally, Moyce suggests including information on discrimination policies into the orientation program (Moyce et al., 2015). The researchers call for stronger support of internationally educated nurses at each stage of their migratory process, and extended workplace orientation to fully utilize the professional skills of migrating nurses (Blythe et al., 2009).

2.6.5 Consequences of nursing migration

In this section I would like to briefly examine the most common negative and positive consequences of nursing migration for sending and receiving countries, and mainly for the migrating nurse and her family. One migratory trend can have some benefits and also some negative aspects, depending from which perspective it is viewed (Freeman et al., 2012a). As the demand for nurses has been increasing worldwide, it has resulted in an intense migration of this group, with at least ambivalent consequences for all involved players (Buchan, 2006b), (Brush, 2008). Considering that nurses most often migrate from poorer countries to more wealthy countries (Kingma, 2006), a large proportion of migrating nurses come to developed countries from countries such as the Philippines, India, and Africa using post-colonial ties as a pull factor (Buchan, 2006b), (Brush, 2008).

16 If the nurse has an extensive experience working in a pediatric neurosurgical ward in her home country, it is much easier for her/him to start working in the same type of unit abroad.

Consequences for sending countries

Uncontrolled permanent migration poses a serious threat to the developing countries in terms of depleting their stock of nurses, i.e. the so-called brain drain (Aiken et al., 2004), (Kingma, 2006). Even migration of only a few experienced health care professionals can restrict the provision of health care services in a small country (Kingma, 2006), (Schultz and Rijks, 2014) and cause the so called "loss of institutional memory", with inadequate supervision and the disrupted transfer of professional knowledge, skills and attitudes to new employees (Kingma, 2006). For example, in a study using registration data from the Nursing and Midwifery Council, the older nurses migrating from Africa meant a loss of experienced staff in Sub-Saharan Africa (Buchan et al., 2006c). The source countries then have to rely on fewer workers who have to manage heavier workloads, without the resources to train more health care workers and retain the future leaders and educators, because they cannot compete with the 5x – 10x higher salaries in destination countries (Glinos, 2015).

On the other hand, the return of nurses who gained new skills while working abroad, sometimes called "brain circulation", could positively influence the provision of health care services in the source country, if the migrating nurses actually intended to return into nursing in their country of origin. It has been argued that temporary, short-term migration is optimal, managed by government contracts for 1-3 years, followed by a compulsory return (Kingma, 2006). Moreover, remittances significantly contribute to the GDP in some countries, especially in the poorest ones (Kingma, 2006), (Bieski, 2007).

Supposedly, 50% of skilled workers return back to their home country after 5 years of migration, but the longer they stay abroad, the less likely it is that they will return (Kingma, 2001). Return migration is more likely to happen if a spouse and/or children are left in the home country. Nurses tend to return more often than doctors (Kingma, 2006), but even nurses intend to stay permanently in some countries (e.g. in the USA) (Sherwood and Shaffer, 2014).

Even if the nurse originally intended to return to her/his home country, a lack of interesting, professional opportunities there may alter this intention. Vavreckova determined this in the general Czech population of skilled professionals who gained special skills and competencies

abroad but could not utilize them within the Czech system. Many of these professionals soon opted for re-emigration or migrated out of their profession (Vavreckova et al., 2006). It is likely that a nurse who gained special skills and knowledge abroad and cannot use them after returning to the home country will do the same. The participants in the MoHProf project also reported disappointment after return because they were not able to use their newly acquired skills in their home country (Schultz and Rijks, 2014).

Consequences for receiving countries

Destination countries experience a mostly positive impact of migration on their health care systems, such as the brain gain, and a decreased shortage of nurses. However, extensive reliance on internationally educated nurses, combined with insufficient orientation, was found to have negative effects on a patient´s outcomes. In hospitals with a favorable nurse-patient ratio (less than 1:4), the place of the nurse´s education did not have any influence on the patients' outcomes. However, in hospitals with the nurse-patient ratio higher than 1:5 and with more than 25% of internationally educated nurses, the mortality was higher and the trend was increasing (Neff et al., 2013).

The Commission on Graduates of Foreign Nursing Schools (CGFNS) conducted a study that assessed self-perception of nursing knowledge and skills of internationally educated nurses practicing in the USA. While acknowledging a proficiency in English, these migrating nurses considered the following skills as less proficient: cardiac assessment and the use of technology and medication administration (Edwards and Davis, 2006). These factors could potentially impact the quality and safety of care. Moreover, the foreign workforce is less stable than the domestic one - it could easily migrate again.

Lately, the USA has acknowledged a continuing reliance on internationally educated nurses. Unlike some other destination countries, the USA is typically a permanent destination for the migrating nurse. The USA has a thorough credentialing procedure in order to protect the consumers. The main current issue is the increasing role of American nurses in safety and risk reduction, which might be approached differently in other countries; further, the language barrier still exists, as well as differences in the organizational aspects of care. Strategies for a safe transition have been suggested previously (Sherwood and Shaffer, 2014).

On the other hand, eighty-one percent of nurses migrating to the USA had a degree education (Davis and Nichols, 2002). Another study conducted in the USA also determined that internationally educated nurses were younger, better educated, more experienced and worked more often in direct care, especially in inner city hospitals and services for seniors in comparison to United States (US) educated nurses (Xu and Kwak, 2007). Also, the similarity of internationally educated nurses with some international groups of patients becomes an extra skill and advantage in the US multicultural society (Sherwood and Shaffer, 2014).

Viewed purely pragmatically, one could agree with Glinos´s example of efficiency, that a destination country vastly saves their resources by hiring qualified health care professionals instead of educating their own (Glinos, 2015). However, such an approach is considered unethical (ICN, 2007b), (WHO, 2010b).

Consequences for the migrating nurse and her family

Since approximately 2010, there has been an increased interest in the experiences of internationally educated nurses living and working in destination countries. Consequently, we now have a much clearer picture about the enormous demands which migration puts on migrating nurses.

Many studies have described the unfair treatment, discrimination, bullying and deskilling of internationally educated nurses by different subjects in the migration process (e.g. employers, clients, colleagues) (Kingma, 2008), (Jose, 2008), (Tregunno et al., 2009), (Blythe et al., 2009), (Cuban, 2010), (Moyce et al., 2015). In a survey of internationally educated nurses working in London, more than half of the respondents felt that their clinical position was appropriate to their role and responsibilities, however only 30% of African nurses felt this way (Buchan et al., 2006c). The positive discrimination of migrating nurses is less common and occurs in the Middle East where the western nurses receive higher salaries (Kingma, 2006). The participants in Bludau´s study also mentioned this issue, as well as the personal discomfort it generated (Bludau, 2012).

In a feminist qualitative study of eight Latvian nurses working as caregivers in Norway, the author describes a deeper lying consequence of migration which is usually not openly

discussed: a complex disruption of the family life of the migrant nurse. In developed countries, the poorly paid care work, which was traditionally carried out by a stay at home mother as unpaid work, is now outsourced to workers from poorer countries. Even though the positive consequences of migration (e.g. economic gain for the family) seem to have a priority, it results in serious negative consequences for the family of the migrant nurse which was left behind (Isaksen, 2012). While this "global care chain" (Bach, 2008) is better documented in Filipino nurses, in past 25 years it became pertinent to female migrants from Eastern European countries.

Moreover, migrating nurses working undocumented in private care settings remain unprotected and legally vulnerable. These nurses are also risking a deterioration of their professional skills (Kingma, 2006), (Haour-Knipe and Davies, 2008), (Kingma, 2008), (Glinos, 2015).

There are other serious social consequences of international migration of nurses. While the decision to leave the whole family behind can be the most difficult, abandoning one's original community and learning to live in a new culture is not much easier. Traditional social patterns are disrupted when the woman has a better paid job than her husband, something which, on the other hand, can contribute to gender equality (Kingma, 2006). Adhikari supports Kingma´s argument that migration can change the traditional view of social roles. Because of the high demand for nurses in western countries, the social position of a Nepali women is changing. Now it is acceptable that a female works as a nurse and even migrates, even though this change still produces some tension in the affected families (Adhikari, 2013).

To conclude this section, it is important to note that a middle range theory on nursing migration has been developed, explaining nursing migration in a more complex way. Nurses seem to be somewhat transformed by the migration experience and they impact others on their return migration. A national collection of valid data on nursing migratory flows is still a challenge, but collecting these data uniformly around the globe is important for an efficient workforce.

Based on recently conducted studies, we are now more familiar with the experiences of migrating nurses. These studies show that migrating as a registered nurse can be extremely

hard, especially during the early stages of migration. The first barrier is the lengthy, demanding and expensive credentialing procedure in the destination country. The next obstacle is the ability to communicate effectively in a foreign language with colleagues, patients and families (in person, over the phone, through nursing documentation, while being assertive, in understanding colloquial language and in using medical abbreviations). Another fundamental obstacle is a potentially different nursing practice, with more clinical and organizational responsibilities, and more autonomy for the nurse (requiring decision making and critical thinking). Similarly, the different health care system in the destination country creates a barrier for the migrating nurses which needs to be quickly overcome (the use of technologies, cultural diversity, autonomy of the patient and holistic care, confidentiality, the need for constant prioritizing and time management.) Therefore, a longer and specific orientation period is suggested for migrating nurses, ideally using a previous migrant as a preceptor. Nurses in many studies reported experiencing discrimination and racism from their colleagues and patients. They felt discriminated personally, financially and regarding the available benefits.

The consequences of migration and their local implications for the safe provision of health care services were, to a certain extent, mapped out in this section as well. These consequences are very complex, depending on from which perspective they are viewed and as such, they pose multiple ethical challenges.

2.7 Migration of nurses from Central and Eastern Europe

In this section I review the studies conducted on the migration of nurses from Eastern Europe and from the Czech Republic. Eastern European nurses have lower salaries and often less optimal working conditions in comparison to nurses in Western Europe. Considering the geographical proximity of countries within Europe, combined with facilitating EU policies, there is a good potential for migration. The few published articles describing the migration from Eastern Europe countries were used in this review, and in order to map the Czech situation, some defended theses were reviewed as well. The Czech Republic did not

participate in any of the recently conducted EU projects, joint actions and studies related to the migration of nurses; a comprehensive study addressing the migration of Czech nurses had not yet been undertaken before this presented study.

Central and Eastern Europe (CEE) is a term used for the group of post-communist countries in that part of Europe. The Czech Republic is one of the CEE countries. Its neighbors are Germany, Austria, Poland and Slovakia. It has about 10.5 million inhabitants and a relatively stable economy and political environment (Alexa et al., 2015). The CR had a GDP per capita of 30,000 US dollars in 2014 and ranked 28th on the Where To Be Born index, ranking similarly to Japan, France, the UK and Spain (Wikipedia, 2016). While an average Czech wage was about 1 000 Euros per month in 2013, the average wage of a Czech general care nurse was about 900 Euros (UZIS, 2014).

Life expectancy in the CR is above average for EU10, but below the average for EU15. Infant mortality is one of the lowest in world. The country has compulsory and universal health care coverage and 7.7% of the GDP is spent on health expenditures, which is less than the EU average. The ratios of doctors and nurses per population are around the EU average, the number of acute beds per population is still above the EU average as shown in a recent report (OECD, 2015c). The ratio of seniors among the Czech population has been increasing (Alexa et al., 2015). Kingma´s comment about “nursing being a vehicle for the development of female rights” (Kingma, 2008) is not relevant for the CR, because officially, human rights are identical in the CR, regardless of gender.

Only 1.3% of the total number of non-EU nationals residing in the EU live in the Czech Republic, which is about 2.5% of the Czech population (European Commission, 2015). In relation to the types of migration, the Czech population reportedly prefers temporary migration, if any at all (Vavreckova et al., 2007). This reluctance to migrate appears to have been confirmed in the period after the accession of the CR to the EU in 2004, when the predictions of initial high levels of migration of health care professionals to the “old” EU states did not materialize (Buchan et al., 2008b).

Soon after the EU enlargement in 2004, the International Labor Organization explored the mobility of health workers from four Central and Eastern European countries. The Czech

Republic was one of the countries selected for a case study. The report confirmed that the outflows from the CR were smaller than expected (Wiskow, 2006). Also in this study, the Czech health care professionals preferred a temporary mode of migration and identified the following reasons for migration: low salaries in the CR, expectations of a better living standard and of better working conditions abroad. The barriers to migration were identified as: separation from family and friends, expensive and lengthy formalities before migrating, difficult living conditions, language barriers, the lack of security to find employment in the CR after return. The main destination countries were: Germany, Austria, the UK, the USA and Canada (Wiskow, 2006), which copies the cascade-type pattern of nursing migration between the OECD countries (OECD, 2008).

The report urged the professional/governmental organizations to collect and publish data about the migration of Czech health care professionals to get a better picture of the migratory flows (Wiskow, 2006).

In the CR, the only information currently used for monitoring the outflow of Czech nurses is the number of requests to have professional qualifications verified which can be then recognized by the authorities in a host country (Hellerová, 2009). However, based on this information, it is not possible to determine whether the applicant actually migrated, to which destination country she/he migrated, or any other important information (Dussault et al., 2009). It is very likely that some nurses will have migrated without applying for this certificate and then worked in the old EU member states in less qualified positions, for example as caregivers in Austria (Gurkova et al., 2013). Data on return migration of Czech nurses are not available at all. Thus, our current knowledge of the recent trends in the migration of Czech nurses responsible for general care is minimal.

Only a few internationally published studies in English on the migration of nurses from CEE countries are available, as compared with the wealth of studies on Filipino and Indian nurses. Three very interesting studies on CEE nurses migrating to Italy were published between the years 2007-2010. The first study examined the reasons of Romanian nurses for migration to Italy, as well as their experiences early after arrival (Palese et al., 2007). The second study followed the same Romanian nurses in a longitudinal study three years later (Palese et al.,

2008). The third study examined the flows of nurses from Moldova to Italy (Palese et al., 2010).

In the first study, Palese and her colleagues studied seventeen Romanian nurses working for six months in Italy. Eighty-eight percent of the nurses migrated for economic reasons[17]. During the interview with the researchers, half of the participants chose to speak Romanian and the other half spoke Italian. Not surprisingly, and consistent with the literature presented earlier, the most difficult moment in their new working environment was the language proficiency test, or when they started to work and were not able to communicate in Italian. Just like other migrating nurses, the CEE nurses had difficulties working with nursing documentation, answering the telephone, working with technologies, and delegating orders instead of only carrying out orders. A supportive nurse in charge, a tutor and an orientation program facilitated their transition. Unsurprisingly, placing an internationally educated nurse into a ward or department similar to one in which she had worked before improved her perception of independence (Palese et al., 2007); this finding was documented also by Sherman (Sherman and Eggenberger, 2008) on internationally educated nurses migrating to the USA.

In the second study by Palese, only ten nurses (out of seventeen) remained in the same hospital after three years, but they seemed to be well adapted to their new environment. Their perceived professional independence was very good in all areas in which they had not been confident six months after arrival. Considering the limits of the sample and the method, it seems that the migrating nurses became highly mobile within the host country (the deciding factor being the highest remuneration possible). The Romanian nurses expected their migration to be temporary (Palese et al., 2008), which is similar to the preferences of Czech nurses.

The third study describes Italy´s recruitment of nurses from Moldova. About 2000 nurses migrate from Moldova every year, which constitutes almost 10% of the Moldovan nursing workforce[18]. The migratory process usually takes about 24 months (from deciding to migrate

[17]The wage in the host county was ten times higher than the wage in Romania.

[18] Wages of nurses in Moldova were increased from 50 Euros a month to 70 Euros, in an attempt to decrease

to arrival in Italy) and costs on average 3000 Euros. From the sample of 110 Moldovan nurses who planned on migrating to Italy, only 25 actually migrated to Italy within one year, none of them worked in the host country as a nurse, 16 of them worked as caregivers, and only 5 applied for the license recognition process (Palese et al., 2010).

As in the case of overseas nurses, nurses from EU10 countries reported that they migrate to the UK because of low salaries and unsatisfactory working conditions in their home country. The English language was originally a strong pull factor, but later, many nurses realized that their language skills were actually not sufficient. When considering return migration, they were worried about finding any employment, and about their new skills not being recognized; the presence of family and friends in the destination country was a strong factor to stay (King´s College London, 2014).

Polish researchers recently found that 12.4% of Polish nurses in a quantitative study had previous experience with professional migration and about 30% of the respondents intended to emigrate in the future due low local wages. The majority of these nurses preferred temporary circular migration to Germany or England and planned to send remittances back to Poland (Szpakowski et al., 2016). However, the large sample of these respondents was self-selected; therefore, the results need to be interpreted with caution.

Hungary has a similar history, living conditions, geographical location, population and number of nurses compared with the CR. Ujvarine reports that the number of nurses planning to leave the country was somewhat similar to the CR, although Hungary seems to report a faster increase of nurses requesting a “work permit” to go abroad. A random sample of 1000 nurses was selected from the Hungarian national register, and these nurses were sent a questionnaire surveying their satisfaction with their working conditions, as well as their intentions to migrate. The response rate was 75.5%. The number of Hungarian nurses seriously considering migration was quite low (3% always, 11% often), especially in comparison with Poland (21%) (Ujvarine et al., 2011) or Slovakia (20%)[19] (Gurkova et al.,

the unmanageable outflow.

[19] The non-randomized character of the sample in the study by Gurková needs to be considered, as the methodological differences could influence the different results.

2013), which are countries with a similarly structured health care system, and with lower wages and less favorable working conditions. However, there is probably a more developed culture of migration in the case of Poland and a convenient destination country in the case of Slovakia.

The Hungarian respondents stated that the most probable destinations were Germany and Austria, followed by the UK. About 57% of the respondents never considered migration. Hungarian nurses with a higher educational level were less likely to consider migration (Ujvarine et al., 2011), perhaps because they held senior and better paying positions with better working conditions. This finding somewhat contradicts the results of some studies mentioned earlier on how the level of nursing education relates directly to the intent to migrate (Xu and Kwak, 2007).

In a Greek study, female health care professionals (qualified nurses and a medical doctor) from Eastern European countries worked in caring professions in hospitals and in households in Greece. The actual extent of this deskilling was not known, as the recruitment was informal and there was not, at the time, any policy in place regulating this situation. As such, deskilling is considered to be wasteful of healthcare resources, but the source country in this case was not willing to use the skills of the potential migrants and the receiving country did not need medical doctors or registered nurses (Groutsis, 2009).

The few nationally or internationally published studies on the migration of Czech nurses explore only certain aspects of their work-related migration. The earlier mentioned quantitative study explored the relationship between turnover intentions and job satisfaction among Czech and Slovak nurses[20], where the Czech nurses reported higher job satisfaction and less frequent intention to migrate abroad than their Slovak colleagues. The migration of Slovak nurses to the CR has occurred in a few waves in the last twenty years, motivated mainly by higher salaries in the CR. In a non-random sample of Czech nurses consisting of 499 respondents, 7.8% of nurses reported considering leaving the CR to practice their profession abroad. This low number is especially interesting in comparison with its Slovak counterpart:

[20] The Czech and Slovak Republics were part of one country (Czechoslovakia) until January 1, 1993. Both neighboring countries share a similar history, culture, language and system of professional education.

20.5% of Slovak nurses in this study were considering migration (N=556). Married nurses and nurses with a higher satisfaction of their "control/responsibility and scheduling" were less likely to consider migration (Gurkova et al., 2013).

In addition to published research, a search of unpublished theses was conducted in order to assess any additional relevant research related to the migration of Czech nurses. I located four final theses describing the migration of Czech nurses in the system www.theses.cz, which gathers the defended theses in the CR. Two were bachelor's theses; two were master's level theses. Although sometimes the used methodologies had certain limitations (e.g. small samples, treating qualitative data quantitatively, issues regarding the sampling process), some of the findings are still worth noting. One additional final thesis was a PhD thesis written by an American author.

Bratinková, the author of the first bachelor's thesis, questioned eleven Czech nurses who previously worked in Saudi Arabia. The largest group of the respondents was between twenty to twenty-five years of age, worked abroad in different intensive care units, held a nursing qualification from a secondary nursing school and found out about working in Saudi Arabia from their colleagues and friends. Mostly, they spent between one to five years abroad. They listed their reasons to migrate as financial motivation, a wish to experience something new, career advancement and improvement of language skills. These nurses returned from Saudi Arabia because they were "tired of the different lifestyle" (eight respondents) and felt that "they had seen it all" (six respondents).

Further, ten respondents reported that they fulfilled their goals, and in an open question, listed the following items, which they gained during migration: ability to travel (7x), fluency in English (5x), financial stability (5x), self-confidence (5x), professional experience (4x). Here, they further commented that "new gates were open to them" and that they got a chance to "get to know themselves". Ten of them would migrate to Saudi Arabia again. Nine respondents worked after the return to the Czech Republic as nurses and three used English in their jobs. These respondents suggested a few issues which would be worth transferring to Czech nursing (higher competences for nurses, preceptors for new nurses, better and empathic attitude towards the patient and his family, detailed algorithms for nursing

procedures, more positive relationships within the multidisciplinary team, safer procedures for medication administration) (Bratinková, 2011).

The second bachelor's thesis about the migration of Czech nurses to Saudi Arabia was completed by Kaufnerová only one year later. From her quantitative study on 35 returning nurses, the author concluded that the motivation to migrate to Saudi Arabia is caused by the low wages of nurses in the Czech Republic, their low social status, low satisfaction with the situation of Czech health care and with the political and economic situation in the CR. The respondents seemed to return from Saudi Arabia with new professional skills. A worrying but realistic finding is that 51% planned another migration at the time of the study and 34% were already abroad. Only 17% wanted to stay in the Czech Republic (Kaufnerová, 2012); moreover, it is not clear whether the last subgroup planned on working as nurses in the CR. The reasons for migration seem to be somewhat different here, except for the omnipresent economic motivation.

The third thesis, written by Palková, was a master´s thesis which studied certain migration aspects of 30 Czech and Slovakian nurses. The author acknowledged her small sample, and even though there are some other limitations to her work, she made some interesting findings. Her respondents worked as nurses in Saudi Arabia, Austria, Switzerland and the UK. The majority of her respondents also decided to migrate for economic reasons, seventeen respondents did not have any problems with the recognition of their education and eight needed to pass an exam before their education was recognized.

Congruent with the international studies on migrating nurses, the biggest perceived negative issue in the early stages of their migration was the language barrier. However, after settling in, the majority of the respondents did not have any work related difficulties in the host country. The relationships at the workplace and the atmosphere abroad was rated as very good or rather good by 90% of the respondents. 93% of the respondents did not encounter "any" or "much" discrimination in the workplace abroad, 70% of the respondents were happier in the workplace abroad than in the home country. Only six nurses planned to return home within the next five years compared with thirteen who did not plan this. Twenty respondents out of thirty did not plan to return to Czech nursing (Palková, 2012).

In the fourth Czech master´s thesis, one which deals with the migration of Czech nurses to Saudi Arabia, the author concluded that Czech nurses in general will not stay in Saudi Arabia in the long term (Babilonová, 2009). This thesis was primarily not available online and I was not able to obtain it from the University of Economics, Prague.

A large amount of very interesting information was collected by Bludau during her research for her PhD thesis entitled: "Searching for respect: Czech nurses in the global economy." The author employed an ethnographic approach in her research; the fact that she is not a Czech nurse herself offered a different perspective on the experiences of nurses migrating to Saudi Arabia. She defended her thesis in December 2012 and the thesis became available in ProQuest in 2013. She described her various findings in three articles published in different anthropologic or sociologic journals.

The author describes the former options for migration out of Czechoslovakia (before the political changes in 1989) as either governmental posting in Soviet-allied countries, or a form of permanent emigration chosen by the individual or forced by the state. She connects this fact with the current lower mobility of Czech nurses. The identified motives for current migration of Czech nurses were all described previously in other studies: low wages together with limited opportunity for professional development in the source country, topped off with the wish for an improvement of their language skills as well as the desire to travel or gain new professional skills (Dywili et al., 2013). Some nurses in her research (p. 93) used migration as a form of protest against the conditions in the home country (Bludau, 2012). This aspect of migration was described in other documents as well (Haour-Knipe and Davies, 2008). Bludau states that the economic and development reasons for migration reflect serious problems of the Czech system (Bludau, 2012), which is in line with the opinion of other migration experts (Solimano, 2010).

On the other hand, the Czech nurses in her study did not indicate that they were survival migrants or quality of life migrants, escaping dangerous or unbearable conditions in their home country. They often seemed to justify their migration as their personal right and choice. Similarly, Czech nurses currently do not choose the nursing profession in order to be able to migrate later. They only recently discovered the opportunities that their profession offers to

them. Electronic media was a very important first channel for informing the potential migrant about this opportunity. The recruitment agencies then must transform an Eastern European nurse into a Western nurse. By doing that, the recruiting agency is empowering the Czech women by "embodying" (giving them) new competencies that make them successful players in the global market. Since Czech nurses prefer temporary migration, during which they get transformed into a western nurse, this transformation later hampers their already difficult re-integration into the Czech health care system (Bludau, 2012).

The author concludes that the Czech nurses are attempting to find professional and personal respect through work-related migration. The originally lower confidence found in Czech nurses was improved by the recruiting agency during the preparation period (Bludau, 2010), and it increased notably with a successful migration (Bludau, 2010), (Bratinková, 2011). However, the demands of migration lead initially to a series of humbling experiences with which the migrating nurse had to cope effectively (Davis and Nichols, 2002), (Magnusdottir, 2005), (Jose, 2008), (Tregunno et al., 2009), (Bludau, 2010).

Even though Bludau (Bludau, 2012) seemed to use a feminist lens in her research, she admits that gender topics only rarely resonated in the interviews conducted with Czech migrating nurses. The participants were willing to accept different views on their human rights as females in Saudi Arabia, potentially because they expected to be professionally respected there. This respect is, according to the researcher, missing in all of the human interactions in Czech health care facilities, and also the typical Czech nursing salary does not express much respect of nurses.

In an article from 2014, Bludau noted how nursing, even though it is a global profession, has developed at different rates across the world with different specifics based on local conditions. She states that Czech nursing changed only little since the communist era (p. 95), and that the profession has lost its status since 1989, but does not explore the topic in further detail. According to her, the Czech nursing practice is still rather informal, compared to the protocols and standards of care used abroad (Bludau, 2014). The issue of up-front discrimination of nurses based on an employee's nationality came up as well (p. 202). However, the nurses evaluated the migration as a positive experience and recommend to

their friends to migrate as well (p. 214), because they realized an improvement of self-worth and respect (p. 266). The author calls for more research on returning migrants, especially on their reintegration (Bludau, 2012).

2.8 Summary of Chapter 2

Among other important issues, this literature review has confirmed that migration is a very difficult step, one which would rather be avoided, just as Kingma stated in 2006. Each potential nurse-migrant in any country around the world most probably carefully weighs the pros and cons of such a move, attempting to maximize her/his opportunities in a global society.

In terms of the overall review of literature on migration in general, and the migration of nurses, one main finding is that the majority of nurses who migrate are moving from low income countries to higher income ones. The number of migrants has been increasing world-wide, while the CR has a low migrating potential. Only about 11% of Czech citizens consider working abroad, they prefer temporary migration, and it seems that even less Czech nurses have similar plans. Interestingly, during the economic downturn in 2008, the Czech Republic had the biggest relative reduction in migratory flows. Considering the facilitating policies, intra-European migration is rather small compared with the migratory flows of non-EU citizens, while the monitoring of these flows is not very exact.

The migration of nurses is currently a global political theme because of its relation to the general shortage of health care professionals and the provision of safe care. Self-sustainability in the production of nurses, improved working conditions, better remuneration of nurses, better health care workforce planning and recruiting are all well-known solutions to the shortage problems. The consequences of brain gain, brain drain, brain circulation and brain wasting are more researched and understood today.

An increased migration very often points to serious problems within the system; and since health care professionals´ migration is a global phenomenon, the causative problems must

be global as well. The financial aspect of migration is almost always the deciding factor and the other aspects of migration are usually less important. Migrating nurses very often pair their financial motivation with another motive such as the wish to improve their language skills, experience something new or learn something new.

The current evidence demonstrates the often negative and exceedingly difficult initial experiences of migrating nurses who typically struggle with achieving efficient levels of communication skills, with fundamental differences in nursing practice and with discriminatory practices in the destination country. The nature of the nursing profession - the need to communicate very exactly with the clients about very sensitive topics - necessitates a deep understanding and a very proficient active usage of the language at an almost native level, as well as an understanding of the sociocultural background. A lack of such fluency will leave nurses feeling “like outsiders” and might influence the quality of care.

The different nursing practices in the destination countries which the migrating nurses had to adapt to mainly included the differently viewed role of the nurse with more autonomous functions, more responsibilities (especially in the area of physical assessment of clients and risk assessment), critical thinking of the nurse, as well as their ability to be assertive and delegate tasks efficiently. Furthermore, the knowledge of the health care system, using modern technologies and respecting the clients´ autonomy, were other problematic areas for migrating nurses. Some authors suggested other topics to be included in a longer and specific orientation period of migrating nurses (e.g. cultural issues, local policies on confidentiality and discrimination). Apart from orienting the internationally educated nurses in certain topics, a mentor who previously was a migrating nurse seems to facilitate the transition, as does placing the migrating nurse in a specialty department in which she/he has professional experience.

While there is not much published research on Czech migrating nurses, it seems that they have to be first transformed by the recruiting agency to be successful in the global market. They will later be inevitably transformed further by the migration, especially towards an increase in their self-confidence and self-respect. The search for respect, which the Czech

nurses do not receive in the Czech health care system, could be another motivator for migration.

Based on my review of the available literature, it seems that only two articles about certain aspects of Czech nursing migration (e.g. job satisfaction and the intention to migrate) were published internationally (in 2006 and 2013). Further, the Czech Republic did not participate in any of the recently completed EU-wide studies on the migration of health care workers. Four recent academic theses exploring the topic of Czech nursing migration were publicly available for my review, and all of them involved the use of non-random sampling of approximately thirty participants. The only indicator used for the national monitoring of nursing migration is the annual number of requests for the recognition of professional qualification. Therefore, for a conceptual framework for this study, a more robust approach was suggested. I used mixed methods research and attempted to collect more quantitative data on all of the known aspects of nursing migration, which I identified in the reviewed literature. Research questions (listed below) reflected the knowledge identified on different populations, as well as the call for testing the newly developed theory on nursing migration. A larger and more heterogeneous sample of Czech nurses was targeted by cooperating with a national professional organization and an established recruiting agency. However, due to the lack of other options, the sample remained non-randomized. The resulting qualitative strand explored and validated the previously collected data.

3 Chapter – Methods

3.1 Introduction to Chapter 3

The main purpose of this study was to explore important aspects of the migration of Czech nurses, because this topic has been under-researched, and many issues, such as the experiences, the outflow and the return of Czech nurses have not been previously explored or published. The review of available literature suggests that the general Czech population does not seem to migrate to the extent which would be expected given the relatively less satisfactory working conditions and lower salaries in the Czech Republic as compared to the neighboring countries in Western Europe. Based on the only available indicator for monitoring the migration of Czech nurses, Czech nurses also do not seem to migrate in large numbers. Another goal of this study was to examine the impact of nurses´ migration on the Czech health care system, especially regarding the utilization of their newly gained professional skills from abroad.

This study aimed to answer the following research questions:

1. What has been the out migration pattern of Czech nurses responsible for general care?

1.1. How do the push and pull theory and the theory suggested by Freeman et al. explain the migration of Czech nurses?

2. What are the motives of Czech registered nurses for migration?

2.1. What are the motives of Czech nurses for return migration and what is the impact of migration on their lives?

3. Can the experience of Czech nurses who migrate be described?

3.1. What is the impact of the Czech nurses´ migration on the Czech health care system?

4. Can an assessment of the number of Czech nurses who migrate but are not employed in the destination country as nurses responsible for general care be made?

This chapter defines the mixed method research approach, describes the reasons for selecting a mixed method research design for this study and justifies its appropriateness for examining the issue of migration of Czech nurses. The migration of health care professionals continues to be intense and on the increase (OECD, 2014); this migration is influenced by many factors and it has multiple consequences, thus mixed method research can be an appropriate approach for giving as a complete picture as possible. This chapter also describes in detail the target population for this study, as well as the sampling procedure. It also details the preparation and the use of the selected instruments (the self-administered questionnaire, the interview guide and the focus group guide). It describes the procedure for pre-testing the instruments, the process of evaluating their validity and reliability, and finally the process of conducting all three strands of this study. The ethical considerations relevant to the study (the approval of the study, the access to the participants, the informed consents in the quantitative and qualitative strands, the anonymity and confidentiality issues) are described in detail. The main limitations and delimitations of this study are also defined in this chapter.

3.2 The selected research design and its appropriateness

Mixed method research is becoming increasingly popular and widely recognized as an approach that can capture complex issues within nursing research (Halcomb and Andrew, 2009). Creswell and Plano Clark define mixed method research as, "…collecting, analyzing and mixing quantitative and qualitative data in a single study. Its central premise is that the use of both approaches in combination provide a better understanding of research problems than either approach alone." (2007, cited in Creswell and Plano Clark 2011, position 272)

Although Polit and Beck were, in 2004, more reserved towards mixed method research, even at that time they also saw the integration of qualitative and quantitative research design as becoming increasingly accepted by the academic community as an appropriate approach to answer certain research questions (Polit and Beck, 2004). Especially in health care research, many researchers from both traditions now seem to accept that how we perceive this world

is affected by our background, that the hypotheses can be rarely tested in isolation and some alternative explanation will always exist. Mixed method research is an inclusive, pluralistic, non-limiting form of research. The weaknesses and strengths of qualitative and quantitative methods even out by combining both methods in one study, and the evidence is then supported more strongly (Johnson and Onwuegbuzie, 2004). Moreover, mixed method research facilitates the development of complex research skills (Halcomb and Andrew, 2009).

Onwuegbuzie and Leach (Onwuegbuzie and Leech, 2006) suggested thirteen clear guiding steps for mixed method research. Also included below are the references to sections of this study where each step can be found.

1. The first step is determining the goal of the study. In the case of this study, the goal was mainly to contribute to the current knowledge base and to improve the understanding of a complex phenomenon.

2. The research objectives were to describe and explore the issues of Czech nurses´ migration.

3. The research rationale (why a study is necessary) is described in detail in Chapter 1. Introduction, Section 1.2.

4. The purpose for mixing was to expand the investigation, which could be achieved only with using different methods.

5. The research questions could then be determined (see Section 3.5.).

6. Sampling design is detailed in Section 3.7.

7. The selected mixed method research design was the sequential exploratory mixed method design with an embedded initial qualitative strand. It is described in Section 3.4.

8. Data collection techniques in all three strands are described in Section 3.8.

9. Data analysis is covered in Chapter 4.

10. Steps for data validation are suggested in Section 3.6.

11. Finally, the data are interpreted in Chapter 5., Discussion.

12. This step describes the report writing

13. The reformulation of the research questions can be found in Chapter 5. Suggestions for future research can be found in Section 5.9. (Onwuegbuzie and Leech, 2006).

The recognized benefits of mixed research are offset by several challenges, mainly by the fact that the collection and analysis of the multiple types of data is extensive and consumes time and resources, and also by the fact that the researcher, as well as the intended audience, needs to be familiar with mixed method research (Creswell and Clark, 2011). Recently, quite a few researchers have approached the topic of nursing migration using mixed method research. Mitchell (2009) used this design in her study on job satisfaction and burnout among foreign-trained nurses in Saudi Arabia, and El-Jardali (El-Jardali et al., 2008) investigated the migration of Lebanese nurses using a mixed method design. Humphries and colleagues (2009) explored the issue of sending remittances by migrating nurses in Ireland in a mixed method study. Zander and her colleagues (2013) used quantitative and qualitative data from two large European projects to map nursing migration to Germany.

Quantitative research has had a longer tradition; therefore, it might have higher credibility with certain people such as experienced quantitative researchers and natural sciences researchers. It is very useful when we need to test and validate already constructed theories or known phenomena; sometimes it is even possible to explain these using quantitative methods. Hypotheses can be tested, results can be generalized, and cause-and-effect relationships can be assessed by quantitative methods. The process of quantitative data collection and analysis is quite quick, mostly independent of the researcher, and it provides us with rather precise and brief numerical data (Johnson and Onwuegbuzie, 2004).

The key concept in qualitative research is to understand the meaning a researched phenomenon holds for the participant(s). It is holistic, and often used in the initial stages of knowledge development. Qualitative research is usually less structured, and the research process can change after the research has begun. The ultimate goal is to learn about all aspects of the research problem. The qualitative researcher is interpreting what she/he sees, hears, or understands, and it cannot be separated from her/his own background (Creswell and Clark, 2011). According to Gibbs (Gibbs, 2008) qualitative research is intended to

approach the world „out there“ and not assume research in specialized research settings such as laboratories, it strives to understand, describe and sometimes explain social phenomena “from the inside“ by analyzing interactions, experiences or documents.

Qualitative research typically relies on words, rather than on numbers, the participants are purposefully selected and their numbers are smaller than in quantitative research. The semi-structured interview within the qualitative research design ensures that specific topics are covered, while the participant is free to talk about the given topic without any restrictions, which facilitates a transfer of detailed information (Polit and Beck, 2004), (Braun and Clarke, 2013). On the other hand, it is more time consuming to collect and analyze qualitative data and the generalization of the findings is limited (Johnson and Onwuegbuzie, 2004), (Gibbs, 2008).

3.3 Theoretical framework

Biesta describes a paradigm or a theoretical framework/worldview as a way of perceiving and explaining the surrounding world (Tashakkori and Teddlie, 2010)(p.95). Creswell recommends explicitly stating the philosophical background guiding the proposed research. Pragmatism is typically used to ground mixed methods research philosophically. It allows us to embrace the previously perceived dualism and utilize all possible methods, which offer the best answer to the research questions. It views our current knowledge as subject of a change in time and does not agree with reducing culture, behavior, etc. to mere neurobiological processes (Creswell and Clark, 2011).

Pragmatism was selected as the practically appropriate worldview in this study, it focuses on multiple data collection methods which facilitate a holistic, complex and deep view of a problem; it is interested in research consequences; and it is oriented towards the “real world”.

According to Gorard, mixing methods is a natural and sensible approach for researching complex issues (e.g. when buying a car we would consider numerical “objective” information

on its fuel consumption, but also qualitative visual data or the experience of another owner) (Tashakkori and Teddlie, 2010)(p. 237). Even qualitative analytical methods use some form of scale describing the amounts (e.g. always, sometimes, rarely, never), while the so called "objective" methods in quantitative research include selecting variables, describing, coding which involves very subjective input, therefore the assumption that quantitative research is fully objective and that qualitative research is only subjective is not realistic. Epistemological disputes about the non-existence of an external world are not relevant in practical life, where we need all possible methods to describe what we perceive as the external world.

The meaning of migration phenomena to Czech nurses, Czech society and Czech nursing at large was explored, and this was in line with the phenomenology tradition. The interpretive phenomenology of Martin Heidegger, which concentrates on the understanding and interpretation of a phenomenon (not just its description) was used in this study. Bracketing presumptions is not part of interpretive phenomenology. The ethnographic tradition would have required participating in, describing and learning from the life of this group, but this research approach was not taken up (Polit and Beck, 2004).

3.4 Types of mixed method research

From the possible types of mixed method research (i. e. sequential explanatory, exploratory, transformative design and concurrent triangulation, nested and transformative design) (Creswell and Clark, 2011), (Halcomb and Andrew, 2009), I selected a **sequential exploratory mixed method design** with an embedded initial qualitative strand, because it seemed to be the most appropriate one for investigating, describing and exploring the various aspects of migration of Czech nurses responsible for general care. A visual diagram of the steps in this type of research is presented below in Diagram 3.

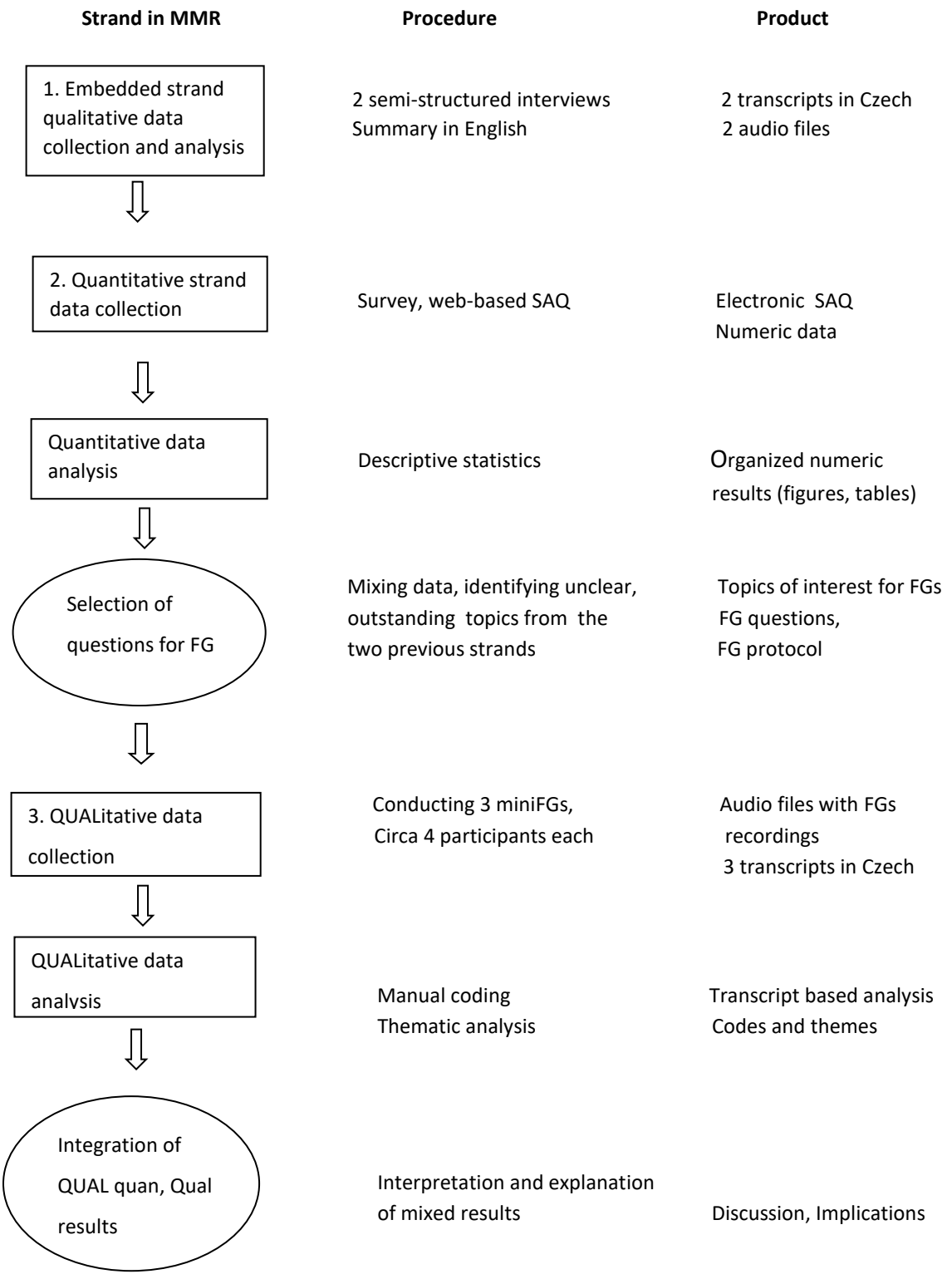


Diagram 3. The steps in a mixed methods study using explanatory sequential design with an embedded initial qualitative strand

1. In the first, qualitative embedded strand, I used semi-structured interviews with a representative from a health care professionals´ recruiting agency, and with a representative

of the appropriate department at the Czech Ministry of Health (MoH), who is responsible for issuing qualification verifications (the Register of Health Care Professionals). The reason for including this strand was the lack of published and official information about Czech migrating nurses and the need for data validation. The first strand was used to inform the later two strands (For the Information sheet and the questions, see Appendix C1 and C2).

2. The second, quantitative strand used non-experimental survey research (Grant and Tomal, 2013) and collected quantitative data from a larger group of migrating Czech nurses using a self-administered, web-based questionnaire to describe the migration experience, the trends in migration, and tested the push and pull theory and the middle range theory suggested by Freeman at al. (2012a) for the group of Czech nurses. The goal was to describe the variables already tested and described in research on other groups of nurses (mainly Filipino, Indian and African) for this new group (of Czech nurses), and by doing so, to be able to understand better the issue of Czech nurses' migration. Another point of interest was the comparison of nurses´ migration experiences in different destination countries. The self-administered questionnaire contained 50 questions (see Appendix C3).

This type of survey research allows for the collection of large number of data, and it can be flexible regarding the topics to be explored, and it can be used with many groups of target populations (except for those who cannot read and write in the given language). However, the information in survey research tends to be rather superficial (Polit and Beck, 2004). The findings of particular interest from the quantitative strand were explored further in the third strand.

3. In the third, qualitative strand, the focus group technique was selected as the most suitable tool for obtaining the remaining information. Focus group research uses a special group of people who have something in common and they discuss a certain topic; its goal is to find a wide spectrum of opinions (qualitative data) about this topic (Krueger and Casey, 2000a). Three mini-focus groups were conducted with selected Czech nurses[21] to help explore the unclear and unexpected topics from the second strand of the study. There were

[21] All the nurses had migration experience and the majority were nurses who had returned to the CR, as one of the explored topic was their ability to utilize skills gained abroad in the CR.

nine focus group questions to be explored (see the Topic guide for focus groups in Appendix C5).

3.5 Research questions

Research question no.	Research question	Topic explored	Relevant questions in the used instruments
Question 1.	What has been the out migration pattern of Czech nurses responsible for general care?	Exploring demographics variables and migration trends	Agency interview question no. 1-6, 13-16 Register interview question no. 1-9 SAQ question no. 1,2,3,6-8,44 –49
Question 1.1.	How do the push and pull theory and the theory suggested by Freeman et al. explain the migration of Czech nurses?	Testing migration theories	Agency interview question no. 9-11 SAQ question no. 27-35
Question 2.	What are the motives of Czech registered nurses for migration?	Exploring the motives for migration	Register interview questions no. 10-11 SAQ question no. 5 FG question no. 4
Question 2.1.	What are the motives of Czech nurses for return migration and what is the impact of migration on their lives?	Exploring return migration	Agency interview question no. 7-8 SAQ question no. 26,37,38,39 FG question no. 2
Question 3.	Can the experience of Czech nurses who migrate be described?	Exploring the migration experience	Agency interview question no. 12 SAQ question no. 4,9-18,36 FG question no. 5,6
Question 3.1.	What is the impact of the Czech nurses´ migration on the Czech health care system?	Exploring the conditions under which the nurses will return into Czech health care	SAQ question no. 40,41,42,43 FG question no. 1,3
Question 4.	Can an assessment of the number of Czech nurses who migrate but are not employed in the destination country as nurses responsible for general care be made?	Exploring motivation and trends of Czech nurses who work abroad in different professions	SAQ question no. 20-25
		Possible contact for voluntary participation in an FG, additional comments (respectively)	SAQ question no. 19,50

Table 1. Research questions

The general mixed method question was: “Do the individual opinions and statements collected in the interviews reflect the data from the quantitative strand and (how) do they enhance our understanding of Czech nurses´ migration?”

3.6 Assessing data quality

The ultimate goal of a research finding is to reflect the reality as closely as possible. The soundness of the quantitative research is assessed by its reliability and validity. Reliability describes the accuracy and consistency of the research data, and whether it would be obtained again in a repeated measurement (Polit and Beck, 2004). The validity means whether the research instrument is measuring the concept it intends to measure (Heale and Twycross, 2015).

3.6.1 Validity

Content validity describes whether the instrument covers all aspects of the measured construct (Heale and Twycross, 2015). Face validity describes "…the extent to which the measuring instrument looks as though it is measuring what it purports to measure." (Polit and Beck, 2004, pg. 718) Content and face validity of the quantitative instrument (the questionnaire) was determined by four experts before the data collection started (see the form for face and validity check in Appendix F1). Further information is on page 89.

Construct validity describes whether the instrument measures the intended construct, this is likely to happen if there is evidence of homogeneity (the instrument measures one construct), convergence (there are other instruments measuring similar constructs) and theory evidence (the theory is in agreement with the results of the instrument).

Criterion validity allows one to compute the correlation of the instrument with other instrument, and whether it measures the same variable in three ways - convergent validity, divergent validity and predictive validity. This means that the instrument correlates with other instruments measuring the same construct, but correlates poorly with instrument measuring other concepts, and correlates highly with future criterions (Heale and Twycross, 2015).

3.6.2 Reliability

One aspect of an instrument's reliability is its stability over time. However, re-administration of the survey questionnaire (test-retest reliability) as a form of reliability testing was not feasible. Another aspect of reliability is the internal consistency of the instrument.

Computing instrument reliability in the form of split-half reliability or Cronbach´s alpha in order to evaluate the internal consistency of the SAQ was not recommended as beneficial in opinion surveys by the cooperating sociologist. Equivalence as reliability aspect relates mainly to observational approaches (Polit and Beck, 2004).

3.6.3 Trustworthiness

Reliability and validity are not fully achievable goals within qualitative research, because this type of research operates within the possible existence of multiple realities or context-bound nature of reality. Similarly, procedures such as inter-rater reliability should not be used for qualitative coding, because coding can hardly be strictly objective (Braun and Clarke, 2013).

According to Lincoln and Guba, trustworthiness has four criteria (Braun and Clarke, 2013)(p. 282):

- credibility (confidence that the data are correct - this could be enhanced by a few means, often by member checking and triangulation, as well as by constant comparison, or searching for disconfirming evidence)
- dependability (stability of the data over time and conditions - this concept is similar to reliability in quantitative research)
- confirmability (objectivity and neutrality of the data (Polit and Beck, 2004), acknowledgement that the methods and results are linked with the researcher's philosophical position and perspective (Noble and Smith, 2015))
- transferability (to other settings and groups) (Polit and Beck, 2004). When we use examples in our research, it should be mentioned whether this example is typical for the whole group or if it is a solitary yet interesting and demonstrative example (Gibbs, 2008). Transferability is the qualitative version of generalizability.

Related to triangulation, we can assume a triangulation of either data, investigators, theories, or methods (Polit and Beck, 2004). Other criteria used in evaluating qualitative research are: reflexivity (recognition that the product of research is strongly connected with some of the background characteristics of the researcher (Gibbs, 2008), including a rich,

verbatim description of participants´ comments to claim the conclusions, reflecting the possible bias in the sample, using a reflexive journal and peer debriefing techniques to uncover further biases and assumptions (Noble and Smith, 2015).

The findings of both qualitative strands in my study were triangulated with each other and with the findings from the quantitative strand in order to increase their credibility. Dependability and confirmability were enhanced by supervision by two experienced researchers; the level of dependability was proved further by similar results (codes) occurring in each of the three conducted focus groups. In order to further assess the confirmability, I consulted the analysis of the qualitative results with another experienced qualitative researcher. Transferability of the findings to other members of the target population could be demonstrated by similar results obtained by Bratinková (2011) in her small scale bachelor study on Czech migrating nurses.

3.7 Sample

Polit and Tatano Beck define sampling as a "process of selecting a portion of the population to represent the entire population. The sample is a subset of the population elements." (Polit and Beck, 2004) (p. 291)

A sample can be selected randomly (probability sample) or non-randomly (non-probability sample); the probability sample is more likely to produce representative results (Polit and Beck, 2004).

3.7.1 Sampling frame

The sampling frame refers to an existing list of the whole population from which a sample can be drawn. The Czech Ministry of Health (MoH) monitors the number of registered nurses through the Register of Health Care Professionals; the stock of registered nurses in the CR has been approximately 100,000 every year since 2006 (NCONZO, 2015). Unfortunately, the software of the Register is not ideal for data retrieval[22]. The Institute of Health Information

[22] A survey of a sample of nurses on the register was considered as a way to answer some of the research

and Statistics of the Czech Republic annually collects the numbers of professionally active health care workers from all of the Czech facilities; the number of professionally active nurses fluctuates around 78,000 nurses (UZIS., 2013), which includes the nurses on maternity leave (its length varies around 3 years). Thus, around 22,000 Czech nurses are not professionally active. While some of them might be (within the last 10 years) retired or taking care of their children, some of these nurses might have migrated or have left the profession.

The Ministry of Health is the national authority issuing the qualification verification; the number of issued verifications is the only indicator of Czech nurses' out-migration intentions. The Ministry does not have any more specific statistics, which naturally hampers our understanding of this phenomenon, but this situation is not uncommon in many other countries around the globe. Therefore, there is not any "list of potential migrant nurses" or any other document which could be used as a sampling frame. Based on the number of issued verifications, approximately 150 Czech general care nurses consider migration every year. These statistics have been available since 2004 and there is an obvious slow but increasing trend. This allows us to estimate that at around 1 500 Czech nurses could have migrated out of the Czech Republic within the last 10 years. Similarly, the two major recruiting agencies in the CR report sending a combined amount of 125 nurses abroad annually.

At the same time, it is necessary to note that many nurses probably migrate without applying for qualification verification (e.g. those working as personal assistants in patients´ homes in the German and Austrian border regions) and without the use of a recruiting agency. Here, even rough estimates of their numbers were not available. The total estimates of the number of Czech nurses with migration experience (who either returned or are still abroad) range from between a few hundred to a few thousand of out-migrating Czech nurses, which would constitute between 0.5% to approximately 2% of the total Czech nursing workforce. However, the exact figure is unknown. To counteract the non-availability of a usable sampling frame, a survey of the members of the cooperating Czech Nurses

questions of this study, but it was determined to be outside the scope of this PhD project for technical reasons but mainly for ethical issues with access to sensitive data in the Register.

Association was considered after its database became fully electronic. The members constitute about 7% of the professionally active nursing workforce, more often in higher age cohorts. Given the time plan of this study, the supervisors did not recommend to undertake this additional survey.

3.7.2 Sampling strategy

1. The two participants in the first strand of the study were purposefully selected because of their expert knowledge of Czech nurses´ migration.

2. Since there was not a more reliable sampling frame, and since the size of the target population remains unknown, in the second strand I had to revert to non-probability sampling strategy. I used a combination of the convenience and snowball sampling method, where the response rate could not be estimated. At the same time, the participation in the survey was self-selected. Because of the sampling strategy, formal sample size estimates were not performed.

All of the limitations mentioned in the previous paragraph have a notable impact on the possibility to generalize the study results to the wider population (Polit and Beck, 2004). Selection bias could be present, as this sample is probably not representative of the whole population. However, no method to obtain a more representative sample was available. The goal of collecting between 100-150 responses, set in the proposal, was met.

3. The participants in the third strand were purposefully selected and recruited via email, using the contacts voluntarily given to me by thirty respondents in the quantitative strand. Later, due to the low numbers of migrant nurses willing to actually participate in this strand, I invited another eleven eligible participants using the convenience sampling technique. Since the number of available participants was lower than expected, I included all of the consenting nurses in the focus groups.

3.7.3 The inclusion and exclusion criteria

Two inclusion criteria for the second and third strand of the study were clearly stated:

a) The participant is a nurse responsible for general care that obtained her/his first nursing qualification in the CR (or previously the Czechoslovak Republic[23])

b) She/he has current or past experience of working outside of the CR.

The following exclusion criteria in the second quantitative strand were applied:

- being a member of a different health care profession (except for four Czech migrating midwives, whose opinions were relevant to this study and were therefore included),
- being originally a Czech citizen but completing the qualifying nursing education abroad,
- being a Slovakian nurse migrating to the Czech Republic,
- having future plans for migration but no previous migration experience.

The reason for excluding the above named categories was the possibility of different migration motives and experiences (as compared to those of the target population), as this study was only concerned with Czech migrating nurses.

In the third qualitative strand, I excluded Czech nurses who worked abroad in other professions than as a registered nurse, because the goal was to explore in depth the migration experience of those Czech registered nurses who worked abroad as registered nurses. From the focus group, I also excluded nurses who meet the inclusion criteria, but reported having family obligations and could not attend the focus group without their children, because the presence of children could disturb the session and it was not possible to organize babysitting.

[23] Primarily, migrating nurses who finished their first nursing qualifying education in the Czech Republic were targeted. Theoretically also the „older" nurses, who graduated before the year 1993 (before the Czechoslovak Republic was divided into two countries) would fulfill the inclusion criteria. In this case, some nurses with Slovakian nationality and Czechoslovak education could have been included, but it does not seem to be the case. On the other hand, nurses who graduated in the Slovak Republic (after 1993) were excluded from this study.

3.7.4 Recruitment of participants

1. There were not any problems recruiting participants for the first strand of the study. Both of the approached informants (a representative of a recruiting agency and a representative of the Czech MoH, the Czech Register of Health Care Professionals) were willing to participate in a face-to-face and phone interview (respectively) in March, 2013.

2. The potential respondents in the second quantitative strand were informed about the study through the official web site of the Czech Nurses Association[24] (CNNA), its Facebook pages, its bimonthly newsletter, through an article in the Czech nursing journal "Florence" ("Migration of Czech Nurses" in October 2012), and through a personal ad in the Czech nursing journal "Florence" in December 2013, inviting nurses to participate in this study, as well as through the "snowballing" technique, making use of the researcher's contacts. Moreover, a representative of the cooperating recruiting agency used emails (in November-December 2013) to contact nurses in their database who fulfilled the inclusion criteria and invited them to take part in the survey.

3. I contacted the potential participants of the third strand in June 2015 via email, in order to negotiate convenient dates for the focus groups during the summer. For this negotiation, I used an online meeting planner application Doodle (www.doodle.com), as recommended by Brown and Clark (2013). The list of participants was obtained in the previous quantitative strand of this study (one item of the SAQ was exploring the willingness to participate in a future focus group).

Originally, there were thirty nurses volunteering to participate in the focus group (FG). However, only six of them reacted to the first recruiting email. The non-responders were contacted again three weeks later and were offered additional dates for conducting the FGs in September 2015. Also, an additional eleven nurses fulfilling the inclusion criteria were invited to participate in the FG.

[24] www.cnna.cz, The Czech Nurses Association currently has about 5271 members who are nurses. This represents about 7% from the professionally active Czech nurses. However, it is not known how many members of CNNA work(ed) abroad.

I asked the representative of the cooperating agency to notify their nursing clients about the planned focus groups, but that did not yield any more participants. Table 2. shows the availability of the invited nurses, the response rate and the given reasons for not being able to participate. In total, about 30% of the potential FGs participants did not answer to my repeated emails, another 25% agreed to participate in one of the FGs. 20% of the potential participants could not participate because they were living abroad at that time, and about 15% had family obligations. Issues with the insufficient recruitment of participants were larger than expected, and I sought the advice of my supervisors. Both of them advised me to continue as planned, even though the conditions were not optimal.

	Originally invited (n = 30)	**Additionally invited (n = 11)**
Did not answer	9	3
Agreed to participate	4	6
Could not participate – family obligation	5	1
Could not participate – is abroad	7	1
Could not participate – no time	5	0

Table 2. Number of participants invited to FGs and their availability

The format of a mini focus group (with four to seven participants), as mentioned by Krueger and Casey (2000a), was utilized. Even though a FG toolkit (OMNI, undated) does not recommend this format, it is now accepted, especially for a focus group with specialists speaking about a highly specialized issue (Krueger and Casey, 2000a). This allows for the thorough exploration of a problem. Yet, on the other hand, the interactions between the participants might be hampered by the smaller number of participants.

The participants in this third qualitative strand were nurses with a mostly tertiary nursing education, unlike the respondents in the quantitative strand (six of the focus groups participants held a bachelor's degree, two had a master´s degree, one finished a PhD degree and one finished secondary nursing school). Their ages ranged from 31 years up to 60 years, with a mean age of 43 years, thus they were slightly older than the respondents in the second strand. Two of them worked at the time of the study as teachers, three were ICU nurses, two were standard floor nurses, one was retired, one worked in policy development

and one worked for an insurance company. One teacher and one ICU nurse were currently on maternity leave. One participant lived abroad and worked there as a nurse at the time of the interview, nine lived (and worked) in the Czech Republic. Three participants worked at the time of the interview as bedside nurses in the Czech Republic, one abroad. Six participants out of ten worked in Saudi Arabia, which could bias the findings, even though one of the "Saudi" participants worked in other western countries as well.

3.8 Data collection tools

3.8.1 First strand: Semi-structured qualitative interview

In order to collect valid data from the CR, where information on nurses´ migration is not publicly available, I had arranged one-on-one semi-structured interviews with two key informants. Interviews have better response rates than questionnaires, allow for deeper questioning and clarity, but are more costly and have a higher risk of interviewer bias (Polit and Beck, 2004). There were only two participants that I intended to interview, which made it possible to conduct the interviews without exhausting the given resources. Burke and Muller offer practical advice on how to conduct a phone interview, which I used when preparing for the interviews. Semi-structured interviews ensure that all of the topics of interests are covered, while the respondent can still answer freely (Burke and Miller, 2001).

The questions for these interviews were developed based on the (mostly English) published literature, as well as on one larger Czech migration study dealing with the migration of the Czech general population (Vavreckova et al., 2006). The questions were critically reviewed by both supervisors with minor amendments.

Both informants had special expertise in this topic that is otherwise not publicly available, and they were able to answer my questions and thus later validate the findings from the other strands.

The interview with the representative of a Czech recruiting agency intended to map the trends in nurse migration from the perspective of a recruiting agency. This Czech-based

agency specializes in the recruitment of health care professionals predominantly for the Gulf region. It has been operating on the Czech market for about 10 years, and so far it has placed over 500 health care professionals abroad. The agency only places nurses in specialist positions. Examples of the questions for the recruiting agency:

- What have been the numbers of Czech nurses responsible for general care that found a nursing job abroad through your agency annually since 2005?
- Do these nurses need a qualification verification certificate issued by the Czech Register of Health Care Professionals?
- Do you have any evidence that these nurses later return to the CR?
- Do you witness a repeated migration of Czech nurses - after they returned from one placement, do they request a second placement in the same country or in a different country?
- Are the patterns of migration and return migration different and specific if the nurse migrates with her family? Is it common that the nurse migrates with her/his family?
- Do the newly migrating Czech nurses prefer foreign health care facilities with an established network of Czech nurses?
- According to you, is there any evidence that the professional skills of the migrating Czech nurses change while working abroad?
- Did you notice a change in the demand to recruit and import nurses since 2009 as a result of the global financial crisis?

The interview with the representative of the Czech Register of Health Care Professionals intended to identify the scope of data in the register relevant to the migration of Czech nurses and to use this information to assess the trends in migration of Czech nurses. The register was established in 2004 as part of the Czech Ministry of Health. Primarily, it checks the credentials of health care professionals (including nurses responsible for general care) who are consequently allowed to use the title „Registered“ and practice the appropriate profession independently. Upon an applicant’s request, the register also issues a certificate confirming the compatibility of the applicant’s professional qualification with Dir.

EU/2005/36 and Dir. 2013/55/EC. This certificate is required by authorities in other countries in order to recognize the applicant's qualifications.

Examples of the questions for the representative of the Czech Register of Health Care Professionals at the Czech Ministry of Health were the following:

- What was the annual number of requests for qualification verification made to the register by nurses responsible for general care that obtained their first nursing qualification in the Czech Republic (or previously the Czechoslovak Socialist Republic)?
- Which age cohorts are requesting the qualification verification the most often?
- Do you know the average highest nursing education of the applicants?
- Can an estimate of the international migration of Czech nurses be made based on data other than the number of requests for qualification verification?
- Are there countries that do not require the migrating nurse to show the verification certificate? Do you think some Czech nurses migrate without applying for the verification certificate?
- Can some nurses be counted twice in your statistics?

The interviews took place in March 2013 in Prague in person with the representative of the recruiting agency and over the telephone with the representative of the MoH with her office in Brno. Both interviews lasted approximately one hour. In the case of the interview with the representative of the MoH, I obtained a verbal permission to conduct such an interview from the Head of the Register in November 2012.

Before I started the interview, I thanked the informants for their willingness to answer my questions, checked whether the timing (scheduled via previous email communication) was still convenient, and confirmed that I was permitted to record the interview (Burke and Miller, 2001), and then we signed the informed consent. In the beginning I explained the QMU procedure to support research clarity, accountability and confidentiality to the informant and then proceeded to ask the first question.

The collection of the information in the semi-structured interview was easy and straightforward. The informants did not have any problems understanding the questions and were willing to share their knowledge with me. This format allowed me to immediately clarify any answers and ask further questions in order to explore the given answer.

I transcribed both interviews verbatim in Czech and prepared a summary in English. The summary of the findings from this strand can be found in Chapter 4. Notes made during each interview were used to check the accuracy of the transcription.

3.8.2 Second strand: Self-administered web-based questionnaire

Since a study similar to mine had not previously been conducted in the CR, I aimed to collect a larger number of responses in my survey of Czech migrating nurses. Between 10/2012-10/2013, I created a questionnaire containing 50 questions (the whole questionnaire is available in Appendix C3).

Migrants are known to make use of communication technologies to communicate with their significant others (Madianou and Miller, 2011). Computer technologies were used to facilitate the maintenance of long distance relationships caused by migration already in 2006 (Tsai, 2006). Further, all of the potential respondents had at least a high school degree, and used computers on a daily basis at work; permanent internet connection and online activities are nowadays very common. Therefore the use of web-based/online SAQ is appropriate for this population (Polit and Beck, 2004), especially considering the variable geographical placement of the potential respondents.

The instrument to collect the data was an online software program (www.SurveyMonkey.com). This software is used for designing, collecting and analyzing surveys. The private, professional and paid plan (called “Plan Select”) seemed to be the most suitable to the needs of this study. However, the literature on how to design questionnaires (Galloway, 2012) recommends highlighting important words or phrases by underlining them or marking them in bold or italics. This feature was unfortunately not supported by the Select plan of SurveyMonkey at that time, even though it would have been beneficial for better clarity of the instrument. Customer support at SurveyMonkey was very helpful and able to rapidly answer questions and explain the functions of the tool.

The questions were inserted into the software using the offered and available tools for distinguishing between the different groups of respondents. I used filters to differentiate between:

a) respondents who had worked abroad in an RN position versus those who had worked in a non-RN position

b) respondents who had returned to the CR after a period of working abroad versus those who were still working abroad.

Further, I used the "skip question" tool to navigate respondents to the next appropriate question based on her/his previous answer[25].

The questionnaire included a brief cover letter, which introduced the researcher, explained the purpose of the study and the inclusion criteria, instructed the respondent on how to proceed, and provided contact details of the researcher, the director of study and an independent adviser. The logo of the supporting organization (QMU) was displayed and the support of the Czech Nurses Organization (the largest professional organization of health care professionals in the CR) was mentioned in the cover letter to enhance the credibility of the study. It also informed the potential respondent about the ethical considerations (including the anonymity and voluntariness) related to this study.

Topics to be explored in the questionnaire were based on the previous literature review; the items of the SAQ answered the seven general research questions (see Table 1). The questionnaire's format was prepared according to current suggestions found in literature (Galloway, 2012) and consulted on with my supervisors, a statistician and a sociologist.

[25] Question 14 redirected the respondent to question 16 after a negative answer,

Question 16 redirected the respondent to question 18 after a negative answer,

Question 26 redirected the respondent to question 28 after a negative answer,

Question 34 redirected the respondent to question 36 after a negative answer,

Question 38 redirected the respondent to question 40 after a negative answer,

Question 40 redirected the respondent to question 43 after a negative answer.

The data collected by this questionnaire were mainly at a nominal level[26], eight times at an ordinal level (e.g. questions 5, 9, 18, 49), once at an interval level (question 35) and three times at a ratio level (questions 37, 44, 45).

Table 3 lists the different types of questions on the questionnaire. The majority of the questions were close-ended questions; four questions were open–ended and another four questions were open-ended numerical.

Some types of closed ended questions in the questionnaire were more suitable for reaching the goals of this descriptive study and were therefore used more often than some other types of questions. Most commonly, the multiple-choice/"Cafeteria" questions (with the option for entering "other" as an answer) were used in order to obtain diverse information from the respondents (Polit and Beck, 2004). The majority of the respondents, however, did not enter any information into the "Other" field. In the multiple-choice questions, the respondents were instructed to select either one or more answers. "No comment" answer options or its alternatives were offered in questions dealing with more sensitive issues. It was intended to offer an "escape" option, so the respondent would not be uncomfortable answering and therefore selecting an untrue option.

[26] e.g. Q. 1. Do you (or did you) work abroad as a registered general care nurse? Yes/No;

Q. 11. After the "orientation period", which was intended for a smooth transition into your first nursing position abroad, you:

- could work without a problem completely independently
- could work independently, with minor problems mainly because of different approach to nursing
- could work independently, with minor problems mainly because of different language
- was not able to work independently yet
- no comment

Dichotomous questions were used only rarely to distinguish between the two groups of nurses, or when collecting demographic data. Matrix rating questions were used four times for exploring the relevancy of the reasons for certain migration-related behavior. Three other questions were rating questions, these used the Likert scale format. In one case the middle (neutral) answer option on the Likert scale was purposefully omitted, to prompt the respondents to choose one of the remaining answers.

Type of question: Close-ended	**Number of this type of question**	**Examples of such questions**
Dichotomous questions	8	Q. 1, 46
Matrix rating questions	4	Q. 5, 9, 22, 39
Rating questions	3	Q. 36, 42
Multiple-choice/"Cafeteria" questions	27	Q. 4, 11, 12, 13
Open ended questions	8	Q. 50, 44, 45

Table 3. Types of questions used in the questionnaire (N=50)

The face and content validity of the SAQ was assessed by a panel of four nurse migration experts (two foreign experts and two Czech experts) who examined each question of the SAQ in summer 2013 (Polit and Beck, 2004). They rated each item on the SAQ for its ability to measure the construct being measured and consequently an Index of Content Validity was computed. The content validity index was 3 (quite relevant) or higher (very relevant)[27] in the majority of questions. The questions about respondents´ current age and parents´ attitude towards migration received the lowest average rating (2.5). The questions about gender, marital status, financial support of the family remaining in the CR, and the list of countries where the nurse worked in other professions received a rating of 2.75. Face validity was identified as „Czech nurses opinions about work related migration" and „Experience of nurses with working abroad, their motivation and coping". The format used for assessing validity can be found in Appendix F1.

Over one third of the respondents, the largest subgroup, indicated in question 28 that they used an agency to work abroad. At the same time, 40% of the respondents migrated to Saudi Arabia. As confirmed by the representative of the recruiting agency, in order to gain a

[27] on a scale where 1 = not relevant, 2 = partially relevant, 3 = quite relevant, 4 = very relevant

working visa to Saudi Arabia, a Czech migrating nurse has to use the services of a certified recruiting agency. Integrating these two findings together can be viewed as supporting the content validity of the instrument. Moreover, since the US questionnaire for internationally educated nurses used in the MoHProf study was available online, it was compared to the draft version of my questionnaire and the items explored in my questionnaire were found to be similar to the MohProf questionnaire, which enhanced the content validity of my instrument.

The questionnaire was originally created in English and translated into Czech by the main researcher. Both language versions were then updated based on consultations with supervisors, a statistician, and a sociologist. Then the **back translation** of the Czech version of the questionnaire into English was performed, using a second independent translator (a native English speaker) in autumn 2013. The back-translation method is a recognized way to ensure that the meaning of the instrument remains the same in both language versions of the questionnaire (Polit and Beck, 2004). Based on the back translation process the following four items of the questionnaire were then changed in both language versions:

1. More appropriate and logical wording of the sentence explaining the anonymity of the survey respondents in the cover letter was used.

2. The term “nursing knowledge” versus “nursing skills” was clarified and this question was divided into two separate questions (No. 12 and 13) in order to avoid “double barrel” questions (Galloway, 2012).

3. A clarification of which country was meant in question 7 was included.

4. A brief definition of the “orientation period” in question 11 was included.

A few grammar issues in the English version were addressed at this point as well. Since Czech was the native language for all of the respondents, and the- “foreign” languages (mainly English or German) differed among the respondents, the Czech version was used for

collecting the data [28] and for the pre-testing round; the English version was used to communicate with the supervisors and the University.

I pre-tested the newly developed on-line instrument on a sample of 10 potential respondents in December 2013, and this allowed me to estimate the time in minutes necessary for filling out the questionnaire (on average 15 minutes), and more importantly to identify any unclear instructions and questions, as well as any problems with the technical functioning of the instrument. Consequently, I made minor technical changes, as well as some larger, content-related changes in the on-line format of the questionnaire (see below). I also checked the technical functioning of the instrument by accessing it from the USA, and did not encounter any problems.

One pre-testing respondent was unable to fill out the questionnaire in the online format, but the other nine remaining respondents did not report any similar technical problems and completed the questionnaire. The SAQ was consequently adjusted based on the following findings from the pre-testing round (Polit and Beck, 2004).

Content issues addressed after pre-testing the questionnaire

- For the pre-testing nurses, the most challenging question seemed to be question No. 1, dividing the respondents into two groups – those who worked abroad as registered nurses, and those who were working abroad in other professions, including other caring professions. Six out of nine respondents answered this question incorrectly because they did not notice or understand the suggested answer options. The format of this question was therefore completely reconsidered and changed to make it easier for the respondents to navigate through and select the correct answers. The used terms were explained in more detail.
- The suggested options for answering questions No. 14 and No. 16 (the experience of discrimination and violence) were unclear to two respondents out

[28] For the sake of brevity and because the majority of the respondents were female, the word endings in the Czech version of the SAQ were used only in the female form.

of nine. The answer options were therefore slightly reworded. One respondent mentioned the experience of a "positive discrimination" of a European nurse in a Middle East country.

- The format of question No. 26 (circular migration) was confusing for two respondents out of nine, its wording was therefore slightly reworded and changed into two clearer questions using a filter.
- The wording of question No. 38 ("After working abroad, did you return to the CR permanently?") was changed to "After a period of working abroad, do you now live permanently in the CR?" to emphasize the permanent return migration of the respondent. Another answer option ("I am currently living in the CR, but I do not know if it is permanent") was added to the existing options in this question as requested by two respondents out of nine. However, even the newly formulated question did not cover all of the possible situations. Three responding nurse commuters[29] had difficulties understanding this question, because they lived in the CR permanently, but they worked abroad and travel to work every day, every week, or similarly. They selected the answer indicating that they live in the CR, but they described their situation in the field for comments. Based on this information I corrected their answers when preparing the data for the statistical analysis.

Technical issues addressed after pre-testing the self-administered questionnaire

- Question No. 35 contained a technical error (it was not possible to enter the answer "I do not know" into a field that was defined as numerical.) The error was corrected.
- I added a filter to question No. 38 ("Where do you work after now having returned to the CR?") in order to skip the following questions Nos. 39-43 for the respondents who indicated that they currently did not work in the CR.
- The questions mapping the important topic of the actual personal experience of

[29]Nurses living in the Czech Republic but working near the border in Germany or Austria. These nurses commute regularly to work "abroad" and they do not participate in the health care workforce of the Czech Republic.

migrating as a RN were moved to the first half of the questionnaire to collect sufficient data on this issue, as it is recommended in the literature, to place the key questions within the first half of the questionnaire (Reichel, 2010).

In January 2014, the final version of my questionnaire was approved by my supervisors and then I posted the questionnaire online for approximately one month (from 17.1.2014 to 13.2.2014) to collect responses from Czech migrating nurses. The link to the SAQ was accessible for members and non-members at the Czech Nurses Association website.

I could constantly monitor the amount of the collected responses on the password protected SurveyMonkey website. The most intense submitting activity lasted during the first few days, with the majority of the questionnaires being collected at this point. Later, only a few questionnaires per day were collected. After the deadline, I transported the returned SAQ from the Survey Monkey website to my password protected computer.

3.8.3 Third strand: Focus groups

When analyzing the quantitative data, it became apparent that the quantitative instrument (the SAQ) indeed could not sufficiently cover and explore all of the researched issues. The third strand of the study therefore aimed at enhancing the understanding of the central phenomenon that was still limited by insufficient information. After the intense and months-long work with the quantitative data (mainly the preparation for an analysis and the compiling of Chapter 4. - Quantitative Results), as well as because of further reading of the relevant literature and consulting my work with my supervisors, the themes which needed to be explored within the focus group discussion somewhat naturally presented themselves. Consequently, they were refined, re-worded, re-formulated and re-organized to comply with the suggestions in the literature for conducting a focus group, an important feature being able to elicit a rich general discussion (Braun and Clarke, 2013).

The focus group questions should use words which would be used by the participants, should sound conversational, should be clear, short and open and give exact instructions to the participants (Krueger and Casey, 2000a), (Krueger, 2002). Eliot and Associates recommend as ideal to ask eight questions in a focus group. Based on this advice I developed a protocol for conducting the focus groups, in which the first two questions were the initial

and engagement questions, their role was to simply make participants comfortable speaking. The following six questions were the key questions, and the last question was the final question, ensuring that any important issue had not been overlooked (Eliot and Associates, 2005). The questions followed a logical sequence from less sensitive topics to more sensitive, were approved by the supervisors, and later pre-tested on three members of the target group. These pre-testers suggested a slight adjustment of the wording of three questions in order to improve their comprehensibility. Examples of the final focus group questions are presented below. The whole guide can be found in Appendix C5.

- Based on your experience, which nursing skills and nursing knowledge gained abroad should definitely be transferred to the Czech health care system? Probe: What experience leads you to this opinion?

- Can you comment on the opinion that, after a couple of years spent abroad, Czech nurses are less likely to return to their home country?
- Can you identify some factors which (would) motivate the migrating nurses to return to working in the Czech health care system?

- What do you think about the statement “A common reason for Czech nurses migration is the improvement of their foreign language skills”? Probe: Can you name some reasons for wanting to improve their language skills? In what sense is the command of a foreign language going to influence a migrant´s (nursing) career?

- What do you think about the possibility for career advancement of Czech nurses while still abroad? Probe: Can you give us an example of Czech nurses assuming or not assuming managerial or more responsible positions abroad?)

- There have been some interesting findings regarding workplace discriminatory practices in a host country. In your opinion, do Czech nurses experience this more, when compared to migrating nurses from other countries?

The most convenient dates for the focus groups, as agreed to by the majority of participants, were 22/8/2015, 2/9/2015 and 23/9/2015. The participants were invited in June, 2015, to allow them to schedule their shifts accordingly. They were repeatedly reminded about the upcoming event after the dates were selected, and then one week, and then one day before the meeting. The FG´s took place in Prague in an education facility. Because of the above-mentioned recruiting problems, two groups had four participants, and in one group there were only two participants. The experts recommend over-inviting participants by 20 %, because it is common that some of the participants will not show up (Krueger and Casey, 2000a), (Eliot and Associates, 2005). Due to recruiting problems, I could not follow this advice; however the participation of the expected nurses was 100%. This is, as detailed in Krueger and Casey (2000), probably caused by the fact that the confirmed participants were highly motivated and interested in this topic, plus their schedule allowed them to participate (most importantly, they were not living abroad at that time).

On the day of the meeting, when the participants arrived, the room was already completely prepared for the focus group, they were welcomed, offered refreshment, shown were the restrooms were and given the information sheet to read and the consent form to sign. The informed consent form contained three demographic items (the age, the highest obtained education and the working place/unit of the respondents), as well as describing the issues of voluntary participation and withdrawal, confidentiality, recording and the possibility of publishing a fully anonymized report. Contacts to the researcher, supervisor and an independent advisor appeared on the consent form (Appendix B3).

The reason for collecting the demographic data was for being able to compare and determine if these participants differed in any way from the respondents in the quantitative strand (the SAQ) - or alternatively, to note if the FG group was more homogenous regarding their level of education or a certain nursing specialty.

At that point, I also distributed gift certificates for popular shops as compensation for the participants´ time and effort (Krueger, 2002), (Eliot and Associates, 2005). I received a Santander grant for organizing and conducting the focus groups and therefore, apart from

paying for the refreshments and organizational costs, I could spend approximately 6 GBP per person on these certificates (receipts are available upon request).

Name tents with the first names of the participants were used to facilitate interaction with each other (Krueger and Casey, 2000a). A useful and practical list of items and actions for preparing focus groups compiled by OMNI (OMNI, undated) was used to ensure an uninterrupted meeting. There were not any interruptions or delays of the focus groups due to logistic issues or any other reasons.

Each focus group was started by introducing the moderator and the note taker and by thanking the participants for their time and effort. The goals of the study were briefly explained together with the following focus group rules written on the board:

- We would like to hear everyone's opinion.
- There are no right or wrong answers, your experience is important.
- We are looking for a variety of ideas and opinions.
- I might call on you or stop you so everybody gets a chance to speak.
- The recording will help the researchers to capture everything said, but nobody will be named or be identifiable in our report. You will remain fully anonymous after this session is over.
- Please respect the confidentiality of the others after the session is over.
- No cell phones please. (Eliot and Associates, 2005).

The discussions were audio-recorded using an MP3 player and a smart telephone (as a backup). Each focus group was just about 70 minutes long. An important aspect of focus group research is to note and use all information available from each focus group session, including how often each participant spoke, agreed or expressed disagreement in some way; their paralinguistic expressions during the focus group session (proxemics – use of personal space, chronemics – use of time (speaking fast, hesitating), paralinguistic – use of voice tone and pitch and kinesics - use of body activity) as well as the impact of the group dynamics (Johnson and Onwuegbuzie, 2004). Apart from following the topic guide during the focus group, which listed the questions to be covered (see Appendix C5), I prepared a protocol to describe the nonverbal behavior of the participants and the group dynamics (see Appendix

C6). However, the nonverbal behavior of all of the participants was very consistent with their verbal behavior in which they were very direct and open, without any signs of limited comfort. Therefore the protocol to record the nonverbal behavior remained unfilled in all groups. The note taker recorded few important observed paralinguistic expressions in her notes, which are included in the transcripts.

The participants seemed well-aware of their level of contribution; they seemed to consciously make space for each other´s reactions. Similarly, I did not notice any problems with "getting the participants comfortable speaking", and usually all participants answered all of the questions. None of the participants was an excessive talker, shy, or other type of participant that would be challenging to the moderator (Eliot & Associates, 2005). I believe this might have resulted from the fact that all of the participants were experienced nurses with a high level of empathy; some of them were used to speaking publicly as teachers and conference speakers. Even though the OMNI material warns against it, four participants seemed to be sufficient to facilitate a rich discussion where everybody had a chance to fully participate (OMNI, undated)

My role in the focus group discussion was to act as the focus group's moderator. This role was to make everybody comfortable, make sure that everybody had a chance to speak about relevant topics, manage the group dynamics, encourage interactions between the participants, be respectful to the participants, and be able to communicate effectively while remaining neutral (Krueger and Casey, 2000a).

Each key question was explored in depth, if necessary using five second silence pauses and probes, with rephrasing and summarizing (long) answers. As the moderator, I strived to remain neutral, but in general it was not very difficult to manage the group dynamics. The time management did not constitute any major problem either, and the groups were naturally able to move on to the next question while the participants seemed to be able to express all of their comments. After each session there was a debriefing period (listening to the audio-recording, comparing it with notes and identifying themes, patterns.) The focus group notes obtained by the note taker closely matched the audio recording.

It was interesting to witness the evolution of my own skills as a moderator. While during the first focus group it was quite difficult for me to limit head nodding and answering “yes” to various comments, already in the second focus group the control over my verbal and nonverbal behavior seemed better and more natural. Based on the recordings, I also improved the speed of my speech and its understandability by speaking more slowly. I should probably strive to speak less in general as a moderator. The recordings were a very demonstrative and efficient tool for adjusting the moderator’s behavior (by the repeated listening to the recording and transcribing it, my moderating skills improved considerably). After conducting the first group, I was surprised by the depth of the focus group discussion in the qualitative research and how it differed from administering questionnaires. The small group dynamics slowly freed more interactions between the participants, and they mentioned some truly deep issues. I shared my reflections with my supervisors.

One imperfection occurred in two groups in relation to question No. 3. (exploring the motives to return to work in the Czech health care system). Here the discussion concentrated on personal motives to return to the Czech Republic in general, instead of on the reasons for returning to work in Czech health care, and I did not steer it back to the original question, which is unfortunate, because the answers in the last group were rather interesting. This experience highlighted the fact that the moderator has to be very familiar with the detailed content of focus group´s topic guide.

The collection of the qualitative data in the focus groups was stopped after the third focus group because all of the available sources (i.e. available Czech nurses with migration experience willing to participate) were exhausted, as described by Lincoln and Guba (1985), (cited in Kruger and Casey, 2000a).

In this study, in order to increase trustworthiness, I employed data triangulation among the different data sets, among data from other studies, and among sources and theories. Due to the mixed design of this study, I could also triangulate between methods. Constant comparison of the researched findings was also used. The participant checking method to further increase the trustworthiness was not used, because I felt like I had already asked my participants to devote considerable amount of time to my research. Instead, I consulted my

findings with my colleagues, and I considered my own possible biases and reflected on the sampling biases or biases related to the chosen method. Detailed record keeping and the demonstration of participants´ views by quoting their rich verbatim were other ways to increase the trustworthiness of the findings (Noble and Smith, 2015).

3.9 Ethical considerations

This study was approved by the QMU Ethical Committee as well as by the Scientific Board of the Czech Nurses Association well before I started to collect any data, in order to minimalize any potential harm to the participants. The Informed Consents (ICs), information sheets, and topic guides were prepared and revised in the English and Czech versions and approved by my supervisors. ICs were signed by the participants in both qualitative strands. All ICs included an information sheet with an introduction by the researcher, contact to my supervisor and to an independent advisor, the goal of the study and the supporting organizations. It also described the inclusion criteria, information about focus group research, and information about the participants voluntary participation and the complete confidentiality of the focus group meeting. These documents are available in the Appendices.

In accordance with QMU policy, the signed Informed Consents have been stored in a safe location for five consecutive years. The audio recordings of the interviews and focus groups were stored in a separate location on the password protected Z drive of the QMU server.

For the quantitative strand, the SAQ respondents were informed in the cover letter that by completing and submitting the questionnaire, the respondent agreed with her/his participation in the survey. This questionnaire was primarily fully anonymous. Only in the case that the respondent wished to participate in a later focus group related to the topic, she/he could enter her/his email address into the SAQ. The IP addresses of the respondents were not used to track the respondent in any way and were deleted before analyzing the data.

The participants in the qualitative part were also informed about the possibility to withdraw from the study without any consequence, and about the confidentiality of the provided information. Only I had access to the recordings of the focus groups discussions. During the transcription of the recordings, numbers replaced all names. As evidenced in Bludau´s thesis, the stories of these participants were so unique that they could have easily been identified by another Czech nurse researcher, even if pseudonyms had been used. In a few sensitive situations, I further anonymized the participants by omitting or changing certain details in the texts of the thesis which will be publicly available (Gibbs, 2008). I also chose not to include the full transcripts in the Appendix of this thesis in order to further protect the anonymity of my participants. Similarly, I planned on preparing a transparent table with the demographics of the participating nurses, but I rejected this approach because of the anonymity issue.

Access to the participants in the quantitative and qualitative strands was ensured partly by the cooperating recruiting agency, and partly by the administrator of the Czech Nurses Association website, and only a few participants were colleagues with whom I have regular contact.

3.10 Limitations and delimitation of this study

One of the main limitations of this study was the nonexistence of a relevant sampling frame, therefore I needed to revert to a non-probability sampling technique, which limited the possibility to generalize the results to the whole population. I decided to use the authority of the biggest professional organization of nurses, the Czech Nurses Association, and its members and website in order to identify and locate nurse migrants. This approach did not allow me to control the selection of the respondents. The respondents in the quantitative survey using a web based self-administered questionnaire were self-selected, which could have constituted a major bias, where only respondents with certain characteristics (e.g. a positive experience as migrants) are motivated to participate.

The correct use of inferential statistic tests was made less feasible by the following factors: the lower number of respondents (N=120), the sampling limits in the second strand of this study, and some of the questions on the questionnaire with many answer options. Based on the recommendation of the consulting statistician, a purely descriptive statistical approach was adopted, without acknowledging any inferential statistics tests (such as the performed Chi – square test or ANOVA test). The amount of, and the characteristics of, non-respondents could not be assessed due to the self-selection design.

Similarly, I was unable to increase the number of participants in my focus group discussions. Because I did not have an extra budget for this study, I could not travel and organize focus groups abroad (e. g. in Saudi Arabia). This fact limited my sample to only nine returning nurses versus one still living abroad (in Saudi Arabia). Nurses currently living and working in western countries were not represented at all in my sample, and I might be missing some important characteristics for describing these nurses who did not return. The available sample was rather homogenous in other aspects as well (middle-aged females living in a big city or nearby), and this could have limited the richness of the acquired information.

The quality and amount of the existing or published data on nursing migration in the CR is another major limitation. Migration is monitored only by the number of issued qualification verification documents, which only indicates the intention to migrate. Additionally, Czech nurses who do not plan on working abroad as a registered nurse do not apply for this document, and when they migrate, they disappear from any possible statistical study.

I was previously a work-related migrant myself, and my perspective and experience could have influenced some of the results´ interpretations, especially in the qualitative strands, even though I strived to remain neutral.

Another limitation was my own smaller experience with conducting mixed method research. To counteract this limitation, I was supported by a PhD supervisor experienced in conducting mixed method research, and by a sociologist. I studied this topic independently and I allocated enough time to carry this study through.

Among the consciously made delimitations was the exclusion of nurses who graduated in Slovakia after 1993 (when Slovakia became an independent state), because technically they were not "Czech" nurses anymore, even though some of their characteristics were rather similar to Czech nurses (culture, language, education). Many of these Slovakian nurses migrated primarily to the Czech Republic and later to other countries as well. This study however deals with Czech Registered nurses only (and with four midwives in the quantitative strand). Researching the migration related behavior of other members of the health care team (e.g. Czech medical doctors, health care assistants, physiotherapists, and lab technicians to name a few) would also be interesting and desirable, but I limited my research to nurses only, because of my knowledge of the details of nursing migration.

3.11 Summary of Chapter 3

This chapter has presented the selected research methods, the preparation of the chosen instruments and the theoretical rationale for their use. This was especially important in this study because the time and resource consuming mixed method research with sequential exploratory design and an embedded initial qualitative strand was used and needed to be justified.

The approval of the study by ethical committees was described in this chapter, as well as the procedure for preparing and obtaining informed consents, and ensuring the anonymity or confidentiality of the participants. The inclusion criteria were defined in this chapter, and the reasons for the use of the non-probability sampling design was justified. Recruitment of the participants and respondents was described in detail.

Lastly, the procedures for collecting data in all 3 strands of this study were described and reflected on. The first qualitative and embedded strand was utilized in order to summarize and confirm important information on Czech nurses' migration. This information is collected to a certain extent by both subjects, by the Czech MoH and by the recruitment agency, but it has not been published. The second quantitative strand allowed for mapping the known variables in the selected population of Czech nurses. The third qualitative strand offered a

deep insight into a few identified topics on Czech nurses' migration which had still remained unclear after conducting the first two strands.

4 Chapter – Results

4.1 Introduction to Chapter 4

This chapter presents the results of the analysis of the quantitative and qualitative data. Firstly, the chapter describes in chronological order how both types of raw data were managed, and then it separately discusses the strategies for analysis of both types of data in all three strands. The selected approaches for mixing quantitative and qualitative data are also described. A large part of this chapter is devoted to a description and display of the actual research results and findings. The findings from the embedded qualitative strand of this mixed method study are presented first, followed by the results of the quantitative strand, and finally, the findings from the focus groups meetings are presented. A short summary concludes this chapter.

4.2 Data management

1. In the **first qualitative strand,** I conducted semi-structured interviews with two key informants. After the interviews, in accordance with QMU policy, the signed informed consents were stored in a safe location. The digital versions of both audio-recordings were stored in a separate location on the Z drive of the QMU server, which is password protected and therefore suitable to hold sensitive, non-anonymous data. Moreover, both interviews were conducted in Czech, which could be viewed as a type of extra protection in the predominantly English-speaking environment of QMU. Storing the raw data at QMU was considered to be more appropriate than storing the data at a nursing organization in the CR. I transcribed both interviews verbatim and after that, I only worked with the anonymous transcripts and the identity of both participants was known only to me. I checked the transcripts against the record and the notes. The informants were de-identified in the transcripts as “a representative of the Czech Register” and “a representative of the recruiting agency.” Based on the anonymous transcripts in Czech, I prepared a summary in English. The findings from this first strand were used during the preparation of the questionnaire (SAQ)

and also when preparing the questions for the focus groups (e.g. the focus group questions 1-3).

2. In the **second quantitative strand** I collected quantitative data using a web-based self-administered questionnaire (SAQ). Collected data were stored at the SurveyMonkey website, which is log in and password protected, and only I had access to them. I later moved the file to my password protected computer. The non-anonymous master version (in Excel format) of the raw data in this strand contained the IP addresses of the respondents, and in thirty cases out of 120, also their e-mail addresses. Only I have had access to this stored master version. Before consulting with the sociologist, I removed the IP addresses from this master Excel file. The SurveyMonkey plan also provided me with a PDF version of all of the submitted anonymized SAQs.

In total, I collected 555 submitted SAQs, however, many of them were not completed and therefore not usable. Due to the high number of the collected responses, a survey reminder was not sent to the remaining potential respondents, which is recommended in the literature (Galloway, 2012).

Working with the Excel table, I manually filtered out the incomplete responses (SAQs not filled out at all, or filled out with irrelevant information, as some respondents just remarked that they "never had a chance to migrate, which is a pity, but before [the year 1989] it was not possible to work abroad" and wished me luck with my study).

I double-checked the usability of the submitted questionnaires against the PDF file (containing the filled in SAQs) before deleting it in order to avoid deleting any usable data. I was then left with 144 completed or partially completed questionnaires (out of the original 555). These SAQs were analyzed in the second filtering round, and the SAQs completed by the respondents who never migrated themselves but described the experience of their migrating friends and students (three respondents), or were educated outside of the Czech Republic (one respondent was a Slovakian nurse working in the Czech Republic, one respondent was a Czech citizen who completed her nursing education abroad and worked as a nurse abroad) were deleted, because they did not fulfill the inclusion criteria. In two cases, the IP addresses were identical, but the given answers were relevant and differed from each

other. I concluded that two nurses filled in the questionnaire on the same computer, and thus I kept these answers for further analysis.

One respondent filled in the SAQ twice, as indicated by her voluntarily provided email address. Her answers differed in a few details (describing her feelings and attitudes) and I kept her original response only. Four respondents were Czech migrating midwives whose views and opinions were relevant to the topic, and I decided to include their questionnaires in the analysis. The cooperating sociologist was consulted concerning the remaining 138 SAQs. She recommended excluding another eighteen submitted questionnaires from my database. These were only partially filled in, containing only a few answers (e.g. only the answers to the first questions as to whether the respondent did migrate as a registered nurse, or migrated and worked abroad in different professions). **The final total amount of questionnaires which were used for analysis numbered 120.**

The sociologist prepared a matrix for coding the quantitative data for SPSS analysis, because the SurveyMonkey plan I selected did not prepare the data for SPSS analysis. At the time, I was not aware of the fact that the output from SurveyMonkey would be an Excel table with the cells containing the full version of one of the answer options. Therefore, at this point I manually coded the fully anonymous data (no IP addresses) into this matrix (in Excel table format) following the sociologist´s advice. The manual coding was time-consuming and increased a risk of making mistakes. However, this laborious detour had certain pedagogical advantages, for it allowed me to become very familiar with the details of data coding for statistical purposes, and it emphasized the benefits of fully exploiting the possibilities of modern technology and software. The sociologist performed tests for inferential statistics using SPSS program. After consulting the correct use of inferential statistics with a statistician, I decided to omit all inferential statistics results and prioritize the qualitative approach to my study due to the lower number of respondents and limits in the sampling approach.

During the coding procedure, I found one questionnaire where the respondent’s answer did not match her/his clarification provided in the text field “Comments”. Based on the

information from “Comments,” I assigned this answer into a different, more appropriate category[30].

While preparing the raw data for SPSS analysis, I randomly checked some answers for logical inconsistencies[31], and I did not discover any. In two questions, the sociologist found a mistake related to the order of the categories, which would have influenced the results. This problem was caused by the fact that the answer options were in alphabetical order in both language versions of the SAQ. The alphabetical order of the answer categories in Czech was different from that in English. This mistake was corrected in the matrix.

3. In the **third qualitative strand,** I conducted three mini-focus groups with Czech migrating nurses. The signed informed consents were stored in a safe location. The digital versions of all three audio-recordings (in an audio format) were stored in a separate location on the Z drive of the QMU server, which is password protected and therefore suitable to hold sensitive non-anonymous data. Again, all focus groups were conducted and transcribed in Czech. During the analysis, I worked with the anonymous transcripts (MS Word documents), and the identity of the participants was known only to me, since I wrote the transcriptions myself. I de-identified the participants in the transcripts by assigning them numbers. All three FG recordings were fully transcribed verbatim for transcript-based analysis (as MS Word documents) (Krueger and Casey, 2000a). I checked the transcripts against the recordings and the notes. Some important paralinguistic features were noted in the transcript as well. Transcript based analysis is more demonstrative and transparent than tape based analysis, moreover Johnson and Onwuegbuzie remark that, "…unless the moderator/researcher is experienced, we recommend transcript based analysis…." (Johnson and Onwuegbuzie, 2004)(p. 5).

After each focus group meeting, the qualitative data were partially analyzed in order to enhance the data collection process in the next focus group (Krueger and Casey, 2000a).

[30] In question No. 30, which explored parents’ attitudes towards migration, one respondent did not select any option from the menu, but entered into the text field “Other”: “My parents did not want me to migrate at all.” Based on this information, I recoded this answer as: “They did not want me to work abroad”.

[31] e.g., When a respondent reported that she spent three years abroad, she stated that she migrated when she was 23 and was now 26 years old.

4.3 Data analysis

1. The information in the semi-structured interviews from the **first qualitative strand** of this study was analyzed from their full transcripts in Czech. A summary of the obtained information in English was prepared. The purpose of this simple analysis was to establish a more official knowledge base of this issue, because at that moment there were not any published analyses of this phenomenon in the CR. After concluding this initial strand of my study, I had confirmed information about the migration of Czech nurses from reliable sources, as opposed to previously unofficial opinions and fragmented knowledge. I used these confirmed findings to inform the two later strands by mixing data between sources and methods. Two informants with expert knowledge were intentionally selected to share the detailed information on the migration of Czech nurses with me.

2. The use of statistics is a common method to analyze quantitative data, and I intended to collect data from a large number of respondents. The goal of this strand was to describe the extent of the nursing migration phenomena in the Czech Republic. Therefore in the **second quantitative strand,** the analysis of the quantitative data was performed using statistical software SPSS 17.0 in summer 2014; for this step, I consulted a sociologist in the Czech Republic who performed the statistical tests, which I then analyzed. The sample consisted of 120 Czech nurses with migration experience, using non-representative, convenience and snowball sampling design. The respondents self-selected to participate in the survey, and a more reliable and representative sampling framework was not available.

The purpose of a descriptive statistics´ analysis is to describe the characteristics of only the study sample. Since the majority of the variables measured in this study was of categorical level, I used percentages and frequencies to describe the findings. The mean, range or standard deviation are typically used to report on continuous variables (Grant and Tomal, 2013).

Inferential statistics enables us to generalize the findings from a sample onto the whole population (Grant and Tomal, 2013). However, the performed inferential statistics tests were not used due to the limits of my sample, as recommended by the consulting statistician.

Given the limiting sampling approach, the number and the characteristics of the non-respondents could not be assessed by evaluating the demographic characteristics of the respondents. Therefore, the sampling bias[32] could not be estimated, and indeed some nurses might have decided not to participate in the survey for specific reasons. Similarly, the sample size estimates could not be performed because the sample was not randomly selected.

The data obtained in this strand were integrated with the findings of the last qualitative strand.

3. In the **third qualitative strand** of this study, I conducted three mini-focus groups with migrating Czech nurses in order to explore the findings from the previous strands in detail and answer the research questions in more depth. I followed a thorough and transparent procedure for the analysis of qualitative data to be able to justify the conclusions drawn from this strand (Grant and Tomal, 2013). I intentionally used the mechanical system for qualitative analysis (a variation to "the long table" technique), as opposed to using any qualitative data analysis software (e.g. NVivo, N6, Atlas, Ethnograph), with the goal of fully experiencing the process of qualitative analysis. Eliot & Associates (2005) suggest using Excel spreadsheets to analyze data from the focus group, and give a detailed description of this process as an alternative to the "long table" technique.

The method of thematic analysis was adopted, mainly because it is suitable for new qualitative researchers. Thematic analysis allows us to recognize themes and patterns across a dataset which relate to our research question (Brown and Clarke, 2013).

The analysis of the qualitative data obtained in the third strand began immediately after conducting the first focus groups (August 2015) and lasted until January 2016. The first step was always a transcription[33] of the focus group recording, as I preferred to undertake transcript

[32] Sampling bias refers to a systematic overrepresentation or underrepresentation of a group of the population with certain characteristics, which has an impact on the representativeness of obtained results (Polit and Beck, 2004).

[33] The focus groups were conducted in Czech, and they were transcribed in this language as well. The codes and themes were developed in English, and the demonstrative extracts of the participants statements were translated into English by the researcher. Inevitably, a certain spontaneity was lost in this translation. One page from two focus groups was translated as well in order to demonstrate the analytical process. See Appendix D1.

based analysis as opposed to tape based analysis (Krueger and Casey, 2000a). The transcription process lasted approximately 10 hours for each recording, and it allowed me to get familiar with the data (for this reason I did not consider hiring a professional transcriber).

After preparing the transcript for analysis, I first read and then carefully and repeatedly re-read the transcripts to further familiarize myself with the data (Braun and Clarke, 2013). Then, while re-reading the first transcript, I marked all the relevant chunks[34] of the participants´ contribution in the transcript with different colored pencils, with each color being a potential code. At this point, I also kept a list of the potential codes. According to Brown and Clark, coding is a process to identify an aspect of the data which relate to a research question. A code is "an expression of the content of the participant's statement by which the researcher should grasp the meaning of the participant's statement" (Braun and Clarke, 2013).

At this stage, the codes were definitely data driven, i.e. expressing what was said by the participants. I continued with this complete coding process (coding across the whole dataset) with the two remaining transcripts, returning back and forth to the list and to the other transcripts, always checking the previously suggested codes and considering their appropriateness (Braun and Clarke, 2013). This method, developed by Strauss and Corbin, is called constant comparison analysis, and is used to check the relevance of the developed codes.

The researcher can approach the actual process of qualitative analysis very individually, including the "long table" electronic approach, or any other suitable approach (Braun and Clarke, 2013). I collated all codes and their demonstrating statements in a color coded Excel table (each focus group had a different color font). For logistical reasons, I preferred this way of collating codes over the use of large roles of paper with relevant chunks glued onto them. During the coding process, I was able to move the chunks to different codes to optimize the answers to my research questions. The next step was to search for candidate themes. Brown and Clarke (2013) describes theme as a category which is broader than a code and has many facets, captures many ideas, but "all are organized around a central concept." A good theme

[34] I omitted coding chunks of the text which did not seem to contribute to answer the research questions (e.g. when the participant got off topic and spoke about their children speaking English in Germany)

should have enough data demonstrating it, should not be too busy and should not be created in a rush (Braun and Clarke, 2013).

I paid extra attention to naming the themes, which should be creative, informative, catchy, short, evocative, as well as making use of the active voice. (Braun and Clarke, 2013) Themes were later reviewed and named, redrafting the names several times. Also, the actual codes and themes were regrouped a few times. In the beginning of my analysis, two candidate themes emerged from the data:

1. The development of the Czech health care system
2. Nursing professionalism

The remaining codes all related to the motivation for migration, and were therefore grouped as such. After more analytical work with the transcripts, I reworked the themes and decided on four:

1. Discrimination
2. Returning home only to migrate again
3. Nursing professionalism
4. Reasons for migration

At that point, I consciously stepped away from the data for a week. When I returned to it, I was able to see the data with fresh eyes, and I decided to collapse theme No. 2 into themes No. 3 and No. 4. After more rewording, a less intense regrouping of codes, and after consulting the findings with my supervisors, I decided to keep the developed codes and themes, because they seemed to give thus far the best answers to my research questions, while fully utilizing all of the participants´ insights.

I analyzed how the themes related to each other and how each of them related to the research questions. When thinking about overarching themes, the topic of “development” seemed to unite a lot of my data. Later, I realized that different aspects of “respect” (e.g. nurses respecting patients, nurses respecting each other, nurses respecting guidelines, other health care

professionals respecting nurses, society respecting nurses) as suggested by Bludau (2012), were present in many codes, and in all of the themes created from my qualitative data.

In January and February, 2016, I performed one last reading of the transcripts and compared them against the suggested codes and themes. Only after I had worked with the codes and themes for around six months was I able to approach the data more creatively and stop relying on their mere description. Also, I consulted the findings with my colleagues (qualitative researchers) at my university and they offered some unexpected feedback which contributed to an explanation of some factors. Consultation with my supervisors was sought as well, resulting in the final version of my qualitative findings. At this point, I re-read the transcripts and I consciously searched for any evidence of the following three concepts mentioned in the literature, which had only recently been suggested to me: transformation, respect and gender – i.e. concept-driven coding (Gibbs, 2008). I found evidence of "transformation", and this reinforced my use of it as one of my codes; "respect" is overarching all of my themes.

4.4 Findings from the first qualitative strand

The following sections present the results and findings obtained in this study in chronological order.

4.4.1 Summary of the interview with the recruiting agency

The recruiting agency, which shared its expertise with me, has been placing about 50 nurses abroad annually. There is one more agency on the Czech market specializing in recruiting nurses to the Gulf region, and they control 70% of the market.

One nurse can be placed (and counted in the cooperating agency´s statistics) more than once a year, but it is very rare. The primary destination is Saudi Arabia. Around five nurses annually are placed in Qatar, up to three nurses annually to the United Arab Emirates. Other experienced nurse migrants might be able to find work in the last two countries without the help of the agency.

The verification certificate is necessary in order to gain employment in Saudi Arabia. The Saudi employers currently prefer two-year contracts with an additional 13th salary[35] and other benefits for the nurses.

According to the informant, the migrating nurse typically stays in Saudi Arabia for two to two and a half years, and then she/he returns home "because of her/his family." In the CR, she/he realizes that she/he cannot find a satisfactory position which makes use of their competencies and offers comparable remuneration to that in Saudi Arabia. Within six months, the nurse migrates again, and this circular migration (Haour-Knipe and Davies, 2008) can repeat twice or three times before she/he has children. Currently, it is not clear what will happen with the Czech returnee nurses after they have had and raised children. Due to the visa system in Saudi Arabia, the nurses have to cooperate with the agency every time they want to migrate to Saudi Arabia.

About 50% of the returning nurses start working in a Czech health care facility, but they typically stay there for only a few months. About 20% of these work in private facilities, 30% in intensive care stations in state owned facilities. Some nurses stay in the clinical environment because they are studying (in a BA or MA program) and they need practical experience, or they already plan on migrating again. The other 50% of the returning nurses seek employment with pharmaceutical companies, clinical studies companies, and foreign health insurance companies. The Czech returnee nurses do not seem to start their own businesses after returning to the CR.

According to the informant, about 60% of the placed nurses are younger than thirty-five to forty years of age. This subgroup of nurses is able to speak some English, they have already traveled and they want to work abroad before they start a family. 20% of the placed nurses are younger than twenty-five years old and 20% are older than forty years old. There are many more well experienced nurses (older than forty years) who are interested in migrating, but the major obstacle in this subgroup is their insufficient language skills, which makes them less attractive to a future employer. Furthermore, in concordance with relevant

[35] 13th salary is a financial benefit provided by the employer to the migrating nurse at the end of a first year of employment. It is usually similar to a normal monthly salary.

literature (Tregunno et al., 2009), (Newton et al., 2012), attaining a good command of English is still the major barrier for the more extensive migration of Czech nurses in general (Bludau, 2012), even though younger nurses study English in school for eight to ten years.

The majority of the placed nurses graduated from a four-year nursing high school and subsequently completed a specialization education (e.g. in intensive care or perioperative nursing). Many completed a 3-year diploma program at a nursing college. About forty to fifty placed health care professionals in total had a Bachelor's degree, up to twenty professionals had an MA degree, and no more than five professionals had a PhD degree. The nurses were placed predominantly in intensive care stations. Nurses with only a four-year nursing high school education are rarely offered a contract in Saudi Arabia.

Only five to ten returning migrant nurses annually receive managerial or teaching positions in the CR. Their potential is not fully exploited by Czech organizations. The migrant nurses want to integrate into the Czech environment again, they are interested in teaching other nurses, but the Czech health care system does not offer adequate positions. The respondent believes that it is paramount to prepare incentives and conditions for the returnee nurses so they would be motivated to stay involved in Czech nursing.

There are some interesting anecdotal reports, such as that some nurses fully comprehended certain professional topics only after working abroad, when they had to participate in specific educational courses and demonstrate that they were ready to work independently in this area. They reported that previously they had performed a certain task "mechanically, without deeply understanding why."

Kingma´s (2006) suggestion that nurses are more likely to return if their family is left behind seems to be valid for the group of Czech nurses. If a Czech nurse migrates with her family, she/he often does not return.

The network of other Czech nurses in a foreign facility does not seem to be a priority for newly migrating Czech nurses, as the offered position and salary is often the deciding factor.

Consistent with the literature, Czech nurses first migrate to large Czech cities and only later make an international move. The agency actually directly recommends this move because the more up-to date equipment and procedures available in teaching hospitals in large cities improve the chances of the nurse to gain a contract.

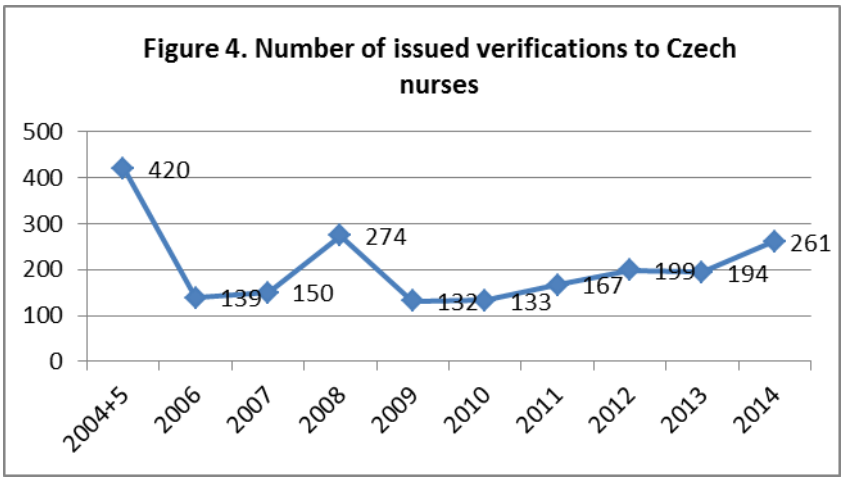
The informant is sure that the professional competencies of the migrating nurses definitely improve and increase abroad. The improvement is so striking that it creates an obstacle for returning to Czech health care facilities.

After the advent of the global crisis in 2009, cheaper nurses from the Philippines were often preferred by employers in Saudi Arabia (a Filipino nurse earns about 3000 USD per month in comparison with a Czech nurse who earns about 4000 USD). At the same time, a "Saudization" is currently occurring in Saudi Arabia, and many positions in standard wards are filled by Saudi citizens. However, Saudi Arabia so far does not prepare a sufficient amount of professionals to work in intensive care units, thus there are still opportunities for Czech specialist nurses to assume these positions. However, the Saudi employers now increasingly request a better command of English and a professional education of at least the college level from the migrant nurse. The representative of the agency expects that demand for Czech nurses in Saudi Arabia will probably decrease in the future, but at this point in time, the Kingdom of Saudi Arabia still relies on migrant nurses.

4.4.2 Summary of the interview with a representative of the Register

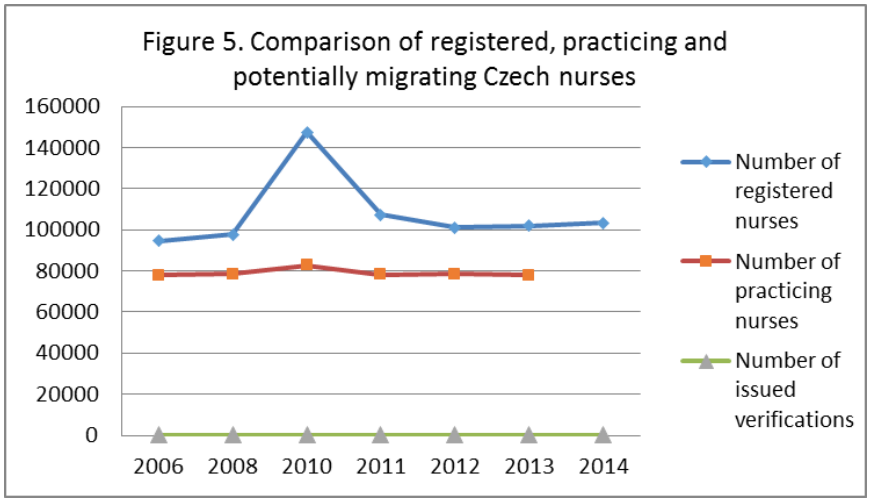
The number of requests for professional qualification verification made to the register by Czech nurses (Fig. 4) are well documented in the register's statistics and remained at around 140 per year, with an unexplained increase in 2008[36], and a slow but steady increase between the years 2010 and 2014 (NCONZO, 2015)

[36] The representative of the Czech Ministry of Health which collected these data was not able to provide any explanation of this peek.



(NCONZO, 2015)

The number of requests for professional qualification verification represents approximately 0.12% of the total stock of general care nurses registered in the Czech Register of health care professionals and 0.21% of practicing Czech nurses in these years (Fig. 5) (UZIS, 2013, NCONZO, 2015).



(UZIS, 2013), (NCONZO, 2015)

The ratio of male nurses to female nurses requesting a qualification verification is similar to the general ratio of males to females in the Czech register. It could be estimated that no more than 5% of the nurses requesting the verification are male.

Data concerning the age of Czech nurses considering migration are not available. The informant estimated that it is mostly younger nurses “after finishing school” and before the age of thirty-

five or forty who request the verification.

The distribution of migrating nurses according to their highest achieved professional education is well documented and it seems to be changing. Before the years 2009-10, the verification was mostly issued to graduates from a four-year nursing high school. After that year, the majority of the applicants had graduated from a tertiary educational institution[37]. The automatic recognition of the qualification according the EU Directive 2005/36/EC now occurs more often.

Approximately ten experienced Czech nurses apply annually for a Czech registration or re-registration as a general care nurse after they return from living abroad for an extended period of time. Only a minimum of Czech nurses who apply for a Czech registration report already having an employer outside of the CR. These are usually Czech nurses who already live in an English-speaking country with a strong tradition of nursing registration, and in order to register as a nurse in the country, they need to prove that they are registered nurses in the country of origin.

If a nurse requests a qualification verification repeatedly within a few years, she/he will appear in the annual statistics every time she/he requests the certificate, but one applicant typically does not apply twice a year.

Consistent with the relevant literature (Kingma, 2006), the informant hypothesized the reasons for the migration of Czech nurses as follows:

- financial reasons and improved quality of life in a certain country
- the potential to gain new experiences
- family reasons (the husband finds work in a certain country), as well as the quite common "commuter migration" of nurses near the Czech-Austrian and Czech-German border.

[37] A tertiary nursing education in the Czech Republic includes either a three-year university based Bachelor's program, or a three-year diploma program completed at a nursing college ("higher nursing school " – "Vyšší zdravotnická škola" in Czech.) Both programs educate nurses responsible for general care and are harmonized with the EU Directive 2005/36/EC, as amended. The nursing education at four-year nursing high/secondary schools (the Soviet model) was discontinued in the CR in 2008.

The future trends of Czech nurses' out-migration will be influenced by the situation in the countries neighboring the CR[38]. The trends in migration of Czech nurses probably will not change dramatically as the Czechs are not normally a migration nation.

According to the informant, there are four typical geographic areas where Czech nurses migrate:

1. The Saudi Arabia, Kuwait – with an easy recognition procedure, the only necessary documents are the verification certificate and the Czech registration
2. The UK – Czech nurses feel that they will not be so severely affected by the language barrier, as they probably studied English in school.
3. Austria and Germany – These are common destinations if there is unemployment in the Czech area near the border, or if the nurses need to improve their personal financial situation.
4. Other countries – e.g. Sweden, Finland, Switzerland. Sweden and Finland, which do not require that the migrating nurse submit a qualification verification certificate as long as her qualification can be recognized automatically, but there are only a few such cases annually.

[38] For example, there was a period of large migration of Slovakian nurses to the CR between the years 2004-2006, which was consequently slowed down by increasing the wages on the Slovakian side. Nevertheless, this increase in wages proved to be unsustainable and the CR is currently experiencing another inflow of Slovakian nurses.

4.5 Results of the second quantitative strandResearch question No. 1: What has been the out migration pattern of Czech nurses responsible for general care?

This research question was answered by analyzing the respondents' answers to questions Nos. 1-3, 6-8, and 44-49 of the SAQ (see Appendix C3).

Valid information was obtained from a total of 120 respondents; 83 reported working abroad as registered nurses (RNs), and 37 reported working abroad in other professions (non-RNs) (Table 4).

Question No. 1 of the SAQ: Do you (or did you) work abroad as a registered general care nurse (was your qualification of general care nurse recognized by the host state?)

		Frequency (N = 120)	Valid Percent
Valid	Worked as Registered nurse (RN)	83	69.2
	Worked in other jobs (Non-RN)	37	30.8
	Total	120	100

Table 4. Number of Czech nurses working abroad as a registered general care nurse (RN) versus in other professions (non-RN)

Answer to question No. 20. *Do you (or did you) work abroad in some other health care or social care profession (for example as a health care assistant, nursing assistant, aide, caregivers, personal assistant, with people with special needs) or in professions unrelated to health or social*

care (for example as a nanny, waitress, cleaner, in a shop, office, factory?) was given by 35 respondents. From the sub-group of the 37 respondents who reported **not working abroad as RNs** (Table 5), 19 respondents worked in a health or social care profession. 16 respondents from the non-RN group worked abroad in other professions unrelated to health or social care.

		Frequency	Valid Percent
Valid	In health/social care profession	19	51.4
	no health/social care profession	16	43.2
	did not answer	2	5.4
	Total	37	100.0
Missing	99	83	
Total		120	

Table 5. Number of Czech nurses working abroad as non-RNs

The mean current age of the respondents was 38.6 years and the standard deviation was 8.3 years. However, the age bands are another meaningful way to describe the respondents´ characteristics, because they can demonstrate the expected time period of professional activity of nurses. Table 6 demonstrates that the biggest cohort (39%, n=47) of the

respondents was between 31 – 40 years of age at the time of this survey. The subgroups of respondents aged 21 – 30 years and 41 – 50 years each constituted approximately 20% of the total. 14% of the respondents left the information about their age blank in the questionnaire.

		Frequency	Valid Percent
Valid	21 - 30 years	20	16.7
	31 - 40 years	47	39.2
	41 - 50 years	23	19.2
	51 - 60 years	13	10.8
	did not answer	17	14.2
	Total	120	100

Table 6. The current age of the migrating Czech nurses (Question 44. of the SAQ)

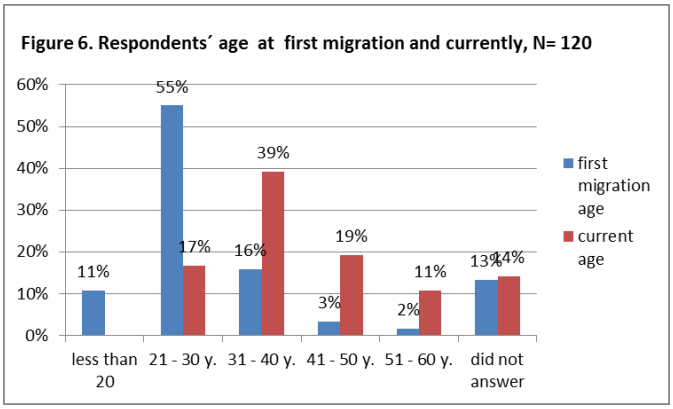
The mean age of the respondents at the time of their first migration was 27.2 years and the standard deviation was 7 years. The majority of the respondents (55%, n=66) was between 21 – 30 years of age at the time of their first migration. 13% of the respondents left this information blank in the questionnaire (Table 7).

		Frequency	Valid Percent
Valid	less than 20	13	10.8
	21 - 30 years	66	55
	31 - 40 years	19	15.8
	41 - 50 years	4	3.3
	51 - 60 years	2	1.7
	did not answer	16	13.3
	Total	120	100

Table 7. The age of the Czech nurses at the time of their first migration (Question 45. Of the SAQ: How old were you, when you first went to work abroad?)

Figure 6. demonstrates the time shift between the respondents´ first migration and the year 2014 when this study was conducted. While more than half of the respondents migrated for the first time when they were between 21 – 30 years of age, currently 40% of our

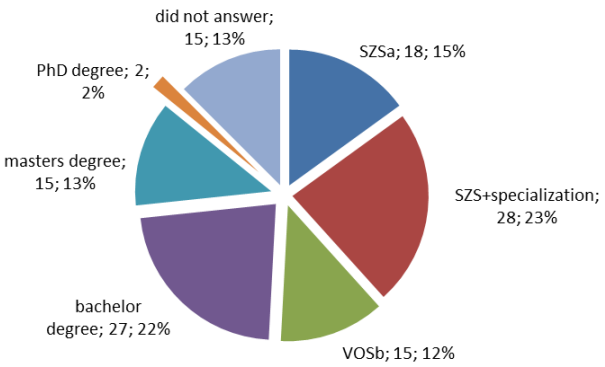
respondents are between 31 – 40 years of age and another 19% are between the ages of 41 and 50 years.



The levels of nursing education completed by the respondents seems to be rather evenly distributed within the sample (Figure 6). Approximately one fifth of the respondents, Czech

registered general care nurses who migrated to seek employment abroad, hold a specialist nursing education degree (23%, n=28), a similarly sized subgroup holds a bachelor's degree in nursing (22%, n=27). Another 15% (n=17) is educated at the masters or higher level. A similarly sized subgroup (12%, n=15) graduated from a three-year tertiary nursing diploma program, 15% (n=18) obtained their nursing education at the secondary level in a four year nursing high school program. Twelve percent of the respondents left this information blank in the questionnaire. However, it is not completely clear from our data when some of the education paths had been completed (the four year nursing secondary/high school, the nursing secondary/high school with a specialization, and the three year diploma program were probably completed prior to the migration; the bachelor's and higher education degrees could have been completed later).

Figure 7. Highest obtained education, N= 120



a) SZS - four-year nursing high schools (the Soviet model of secondary education for nurses)

b) VOS - post-secondary, three-year diploma program completed at a nursing college ("higher nursing school"), compatible with the EU Directive 2005/36/EC, modernized by Directive 2013/55/EU.

The vast majority (81%, n= 97) of our respondents were female. 7.5% of the respondents were male (See appendix G1, Table G1.46), which is slightly more than what was expected by the representative of the Czech Register (less than 5%). Approximately 11% of the respondents left this question blank. Because of the small ratio of male Czech migrating nurses in our sample, the variable "gender" was not explored further.

The most commonly reported destination country of the Czech RNs (Table 8) was the Kingdom of Saudi Arabia (40% of respondents, n=33). The second most common destination country was Germany with 19% (n=16). More rarely, our respondents worked as RNs in the UK, Austria and Ireland, and the USA. Twelve respondents reported migrating to the following "other countries": Three respondents to Switzerland, two to The Netherlands, two to South Africa, and one respondent each to Australia, Finland, Jordan, Slovakia, and Zambia (total of 14,5%). Two percent of the respondents left this information blank in the questionnaire. (Question 6. of the SAQ: In which country do you work (or did you work most recently) as a registered nurse?)

		Frequency	Valid Percent
Valid	Ireland	4	4.8
	Germany	16	19.3
	Austria	4	4.8
	Saudi Arabia	33	39.8
	USA	3	3.6
	UK	9	10.8
	other country	12	14.5
	did not answer	2	2.4
	Total	83	100
Missing	99	37	
Total		10 120	100

Table 8. Destination countries for Czech nurses working as RNs

Table 9 presents the destination countries regrouped according to the language spoken locally. The Czech nurses migrated the most often to Arabic countries (42%, n=35), the

second most common destination were the German speaking countries (30%, n=25), followed by the English speaking countries (21%, n=17). The reason for recoding the countries provided more clarity when presenting the data. Finland, Jordan, Slovakia and Zambia remained as “other countries“ after recoding.

			English speaking countries	German speaking countries	Arabic countries	other countries	did not answer	Total
work as RN	yes	Count	17	25	35	4	2	83
		% within 1_work as RN	20.50%	30.10%	42.20%	4.80%	2.40%	100.00%
Total	Count		17	25	35	4	2	83
	% within 1_work as RN		20.50%	30.10%	42.20%	4.80%	2.40%	100.00%
	% within 6_country recode		100,. 0%	100.00%	100.00%	100.00%	100.00%	100.00%
	% of Total		20.50%	30.10%	42.20%	4.80%	2.40%	100.00%

Table 9. Destination countries recode cross-tabulated with the RN profession

The respondents working abroad as non-RNs migrated mostly to the UK (32%, n=12), and to Germany (27%, n=10). Six respondents in total (16%) migrated to the following “other country“: 2 respondents to Australia, and one respondent each to Switzerland, Israel,

France, and the Netherlands. Eight percent of the respondents left this information blank in the questionnaire (Table 10). (Question 23. of the SAQ: In which country do you work (or did you work most recently) in a profession different than as a registered nurse?)

		Frequency	Valid Percent
Valid	Ireland	1	2.7
	Germany	10	27
	Austria	1	2.7
	USA	4	10.8
	UK	12	32.4
	other country	6	16.2
	did not answer	3	8.1
	Total	37	100
Missing	99	83	
Total		120	

Table 10. Destination countries for Czech nurses working in other professions (non-RNs)

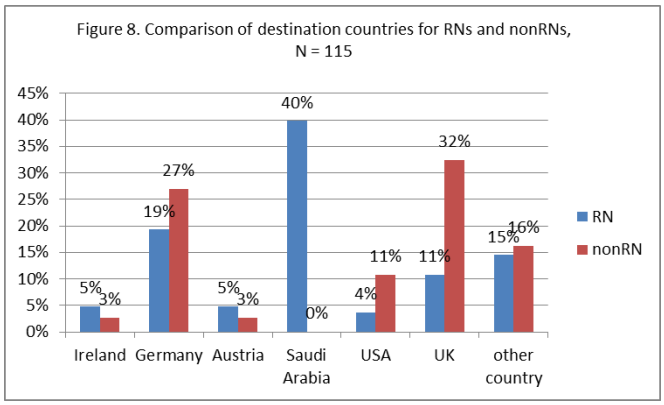
Table 11 presents the non-RNs' destination countries regrouped according to the language spoken locally. The reason for recoding the countries was to provide better clarity when presenting the data. More than half of the respondents worked as non-RNs in English

speaking countries (51%, n=18) and 37% (n=13) of our respondents worked in German speaking countries. Israel and France remained as “other countries“ after recoding.

		Frequency	Valid Percent
Valid	English speaking countries	18	51.4
	German speaking countries	13	37.1
	other countries	2	5.7
	did not answer	2	5.7
	Total	35	100
Missing	99	85	
Total		120	

Table 11. Destination countries recode for Czech nurses working as non-RNs

There was a difference between the destination countries for the Czech nurses who migrated as RNs versus the Czech nurses who migrated as non-RNs. The Kingdom of Saudi Arabia hires Czech nurses only to fill in the positions of registered nurses. The majority of our respondents migrated to Saudi Arabia. An interesting trend can be noticed for the UK, where three times as many respondents migrated as non-RNs (Fig. 8). Five respondents (10.5%) did not indicate their destination country. This information was not included in this figure in order to enhance the figure´s clarity.



4.5.2 Research question 1.1.: How do the „push and pull theory“ and the theory suggested by Freeman et al. explain the migration of Czech nurses?

This research question was answered by analyzing the respondents’ answers to questions 28-35 of the SAQ (see Appendix C3).

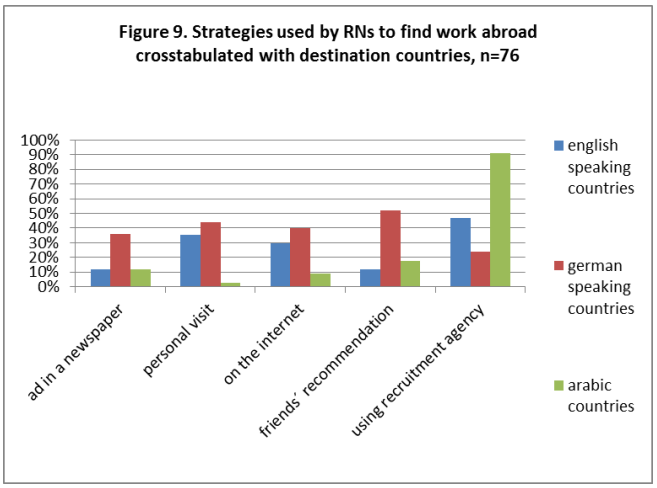
The respondents were asked to indicate their typical strategy for finding a job abroad. *(Question 28 of the SAQ: When you looked for a job abroad, the most effective method was: Please choose every answer, which describes your situation).* Multiple answers were possible. The most common method of finding job abroad among our respondents was to use the services of a recruiting agency (53%, n=60 out of 170 submitted responses) (Table 12). This finding is in line with the most common destination country identified in this survey – the Kingdom of Saudi Arabia, where a working contract can be obtained only with the help of a recruiting agency.

		Responses		Percent of Cases
		N	Percent	
28_finding work recode[a]	28_finding work_newspaper	21	12.4%	18.6%
	28_finding work_personal visits	27	15.9%	23.9%
	28_finding work_internet	26	15.3%	23.0%
	28_finding work_recommendation	36	21.2%	31.9%
	28_finding work_agency	60	35.3%	53.1%
Total		170	100.0%	150.4%

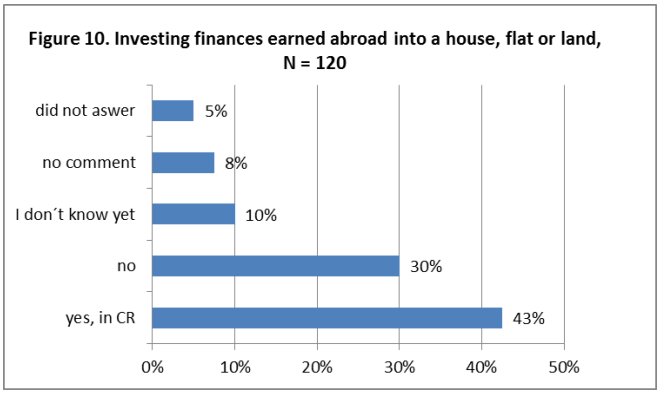
a. Dichotomy group tabulated at value 1.

Table 12. Strategies used by Czech nurses to find employment abroad

Figure 9 demonstrates the need to use a recruiting agency when applying for an RN position to Arabic countries (the Saudi Arabia) (n=31). The RNs working in Germany used newspaper advertisements more often (n=9) and the recommendation of their friends (n=13). The results for the non-RN group were rather similar to the ones of RNs, naturally excluding the results from the Arabic countries.

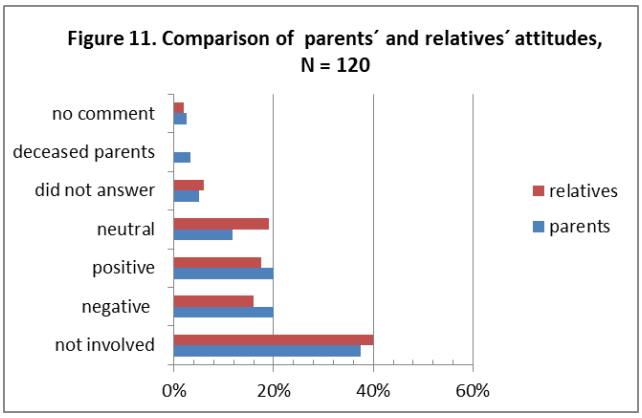


Approximately 43% (n=51) of the Czech respondents invested the money earned abroad to buy a house, flat, or land, or to reconstruct an existing house or flat in the Czech Republic. Another 30% (n=36) did not buy any real estate with the finances earned abroad (Fig. 10). One respondent selecting "other answer" invested her money into her children's education; this respondent is not included in this Figure. *(Question 29. of the SAQ: Did you use/are you using the money earned abroad for buying a house, a flat, or reconstructing one of the above?)*

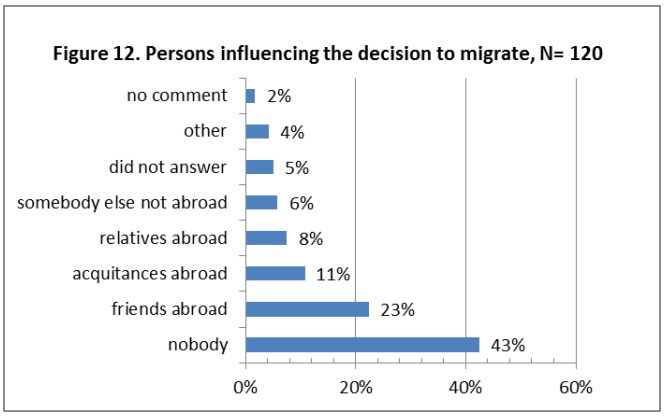


Two questions in the SAQ explored the attitude of the respondents´ parents and relatives towards the respondents´ decision to work abroad. *(Question 30: What was your parent(s) attitude towards your decision to work abroad? Question 31: What was your relatives´ attitude towards your decision to work abroad?)* The reported attitudes of the respondents´ parents and relatives were almost identical. The most commonly selected answer by the respondents was that the parents and relatives "did not get involved" (Figure 11, 40%). About 20% (n=20) of the parents/relatives were negative, and a same number were positive about the decision. 12%

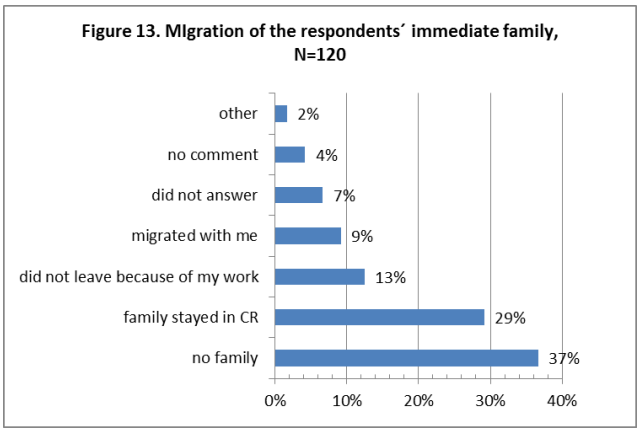
(n=14) of parents and 19% of the relatives were neutral about this decision. 3% (n=4) of respondents selected “other” and they specified that their parents were deceased at the time of their first migration. The performed cross tabulation did not reveal any relevant trends.



Mostly, the respondents were not influenced by anybody in their decision to migrate (43%, n=51). If anybody influenced the respondents to migrate it was “friends” and “acquaintances that had left earlier” (23%, n=27 and 11%, n=13 respectively). 8% (n=9) of respondents were influenced by “relatives who had left earlier.” In the category “other,” the respondents listed a wife, child, or boyfriend, and twice “the conditions in the CR” (Figure 12). The performed cross tabulation did not reveal any relevant trends. *(Question 32. Of the SAQ: Did somebody positively influence your decision to go abroad?)*



The largest group of the respondents (37%, n=44) reported that they did not have their own family at the time of migration (Fig. 13). However, one third of the respondents (n=35) left their partner/children in the home country. 13% of our respondents did not migrate primarily because of their work, they had other reasons for migration. A few respondents 9% (n=11) took their immediate family with them. The performed cross tabulation did not reveal any relevant trends. *(Question 33. If you originally went abroad because of your work, did you take your partner/children with you?)*



The largest group of the Czech migrating nurses did not send home any remittances at all (37%, n=44) and another 21% (n=25) send remittances home rarely. 16% (n=19) of respondents omitted this sensitive question (answers "no comment and "did not answer" combined). 21% (n=25) of our respondents reported sending remittances "every month" (Figure 14). *(Question 34. Of the SAQ: Do you or have you supported your family in the CR with your foreign salary?)* Only few respondents specified what per cent of their yearly salary they remitted.

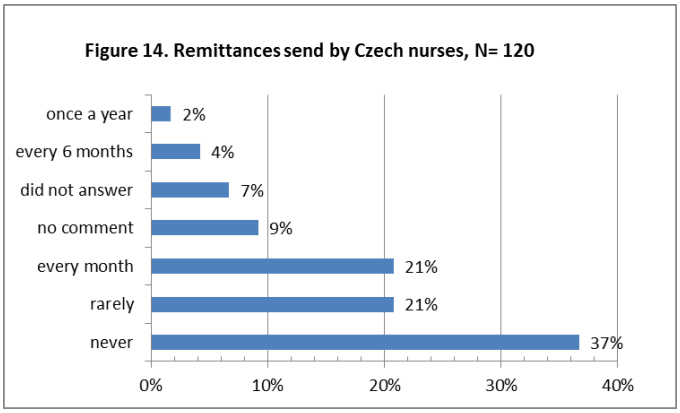
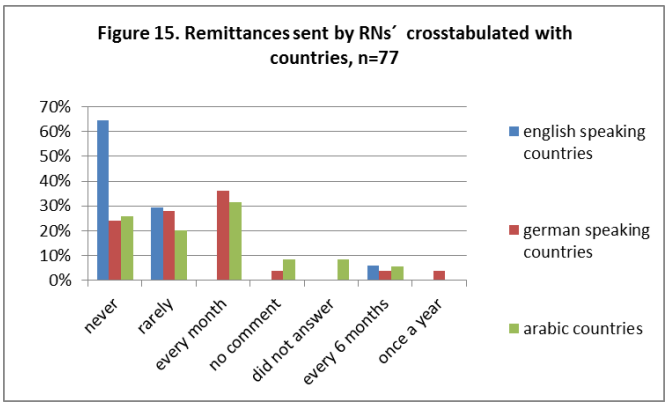


Figure 15 cross tabulates the destination countries with sent remittances. In this sample over 60% (n=11) of the RNs working in English speaking countries did not send home any remittances at all, and 30% (n= 5) only rarely. The results for German speaking and Arabic countries are more evenly distributed.

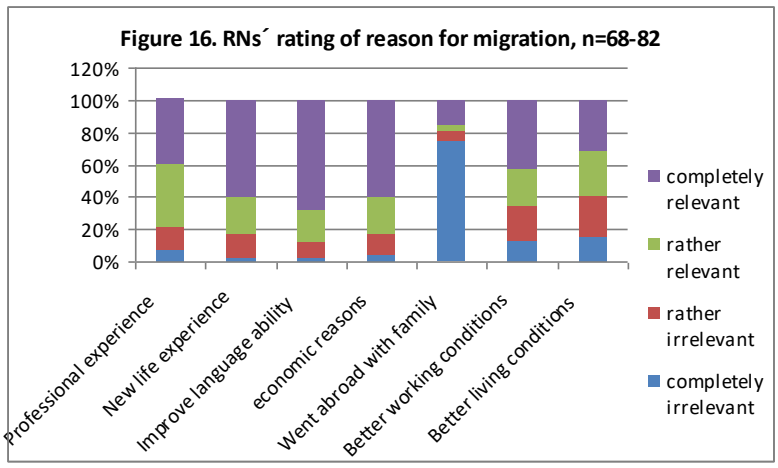


4.5.3 Research question 2: What are the motives of Czech registered nurses for migration?

This research question was answered by the respondents´ answers to question 5 of the SAQ.

Within the subgroup of Czech nurses who worked abroad as RNs (n=83), between sixty-eight and eighty-two respondents rated some of the suggested reasons for their migration. Some of the reasons were rated by almost all respondents (e.g. "I wanted to have a new life experience", "I wanted to improve my economic situation" – 82 responses). Some other reasons ("I went abroad with my partner", "I left for better working conditions" and "I left for better living conditions") were rated only by 68, 77, and 73 respondents respectively. The respondents were asked to rate each given reason for migration on a scale 1 - 4, based on their personal situation, "1" meant "completely irrelevant to my situation", and "4" meant "completely relevant to my situation*". (Question 5. of the SAQ: What led you to decide to work abroad as a registered nurse? Assign points to each answer based on its importance in your situation.)*

Figure 16 describes the RNs ratings of the suggested reasons for migration expressed in per cents. The first four items were completely or rather relevant to 80% of the sample. On the other hand, the item "I went abroad with my partner/family" was completely or rather irrelevant to 80% of the respondents. The relevancy versus irrelevancy of the two items exploring better working and living conditions as a reason for migration was more evenly distributed in our sample. In the open question, the Czech respondents did not present any other reasons for migration which had not been previously mentioned in the literature. Table G1.16 is in Appendix G1.



4.5.4 Research question 2.1.: What are the motives of Czech nurses for return migration and what is the impact of migration on their lives?

This research question was answered by the respondents' answers to questions Nos. 26, 37, 38, and 39 of the SAQ.

Question 38. Explored return migration (*After a period of working abroad, are you currently living permanently in the CR?)* A total of 62% (n=74) of Czech migrating nurses from our sample stated that they had eventually returned to their home country (the Czech Republic) after a period of working abroad (Table 13). 46% of all respondents (n=55) selected the answer "Yes, I returned home". Another 16% (n=19) of our respondents selected the option "I am currently living in the CR, but I am not sure whether the return is permanent". A similar number of respondents (14%, n=17) was still abroad at the time of the questionnaire completion (they selected the category "not yet") and 10% (n=12) of Czech migrating nurses "did not live in the CR at the moment and did not plan to return" to the Czech Republic[39]. Thirteen respondents did not answer in this question at all.

		Frequency	Valid Percent
Valid	I returned home	55	45.8

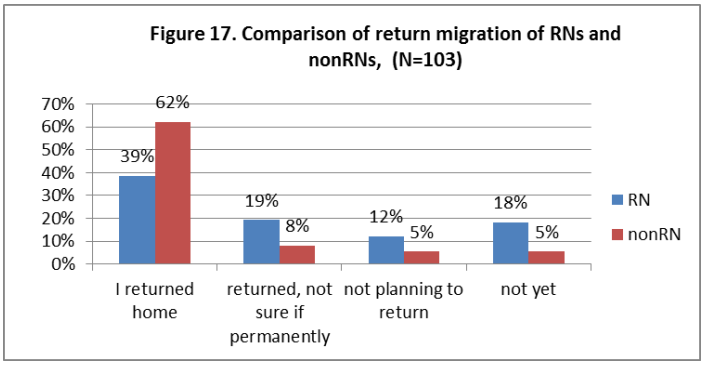
[39] Even though the number of older respondents was lower, cross tabulating the return migration status and the current age of the respondents showed an increasing trend in return migration in older respondents (up to the age 51-60 years). At the same time, the intention of "not planning to return" decreased with the age of the respondents to zero in the subgroup of respondents age 51-60 years.

	returned, not sure if permanent	19	15.8
	not planning to return	12	10
	not yet	17	14.2
	other	4	3.3
	Did not answer	13	10.8
	Total	120	100

Table 13. The return migration of Czech nurses

Four respondents specified their return migration status in the comment only. I primarily focused on "brain drain" (losing qualified and often highly skilled professionals from the national workforce). All four actually belonged to the category of respondents who have not returned yet ("not yet") because two were commuters, one had just migrated again, and one was still abroad. Mistakenly, all four answers are expressed as "Other" in Table 13. In reality, the category of respondents still abroad (answering: "not yet") would rank as the second largest in our survey with 17.5%, n=21.

While **39%** (n=32) of the Czech nurses working abroad as **RNs returned** home after a period of migration, **62%** (n=23) of the nurses working abroad as **non-RNs returned to the home country**. The respondents in the subgroup of RNs (the blue bar) were also more often still abroad, were not planning to return or were not sure if their return was permanent (Figure 17). The category "other" was not included in Figure 17 in order to enhance the figure's clarity.

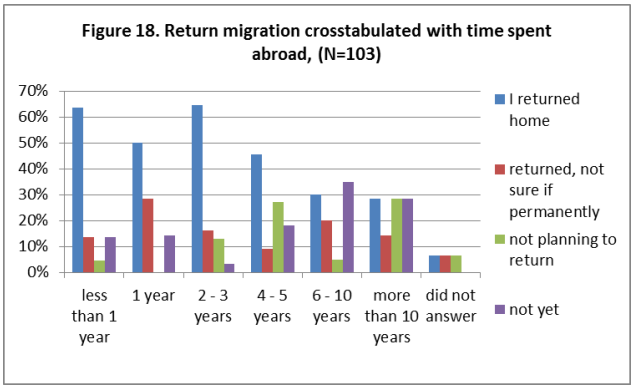


Question 37 of the SAQ explored the total length of migration *(How long in total did you approximately spend abroad? Enter number of years/months).* The most commonly reported period of emigration, stated by 25.8% (n=31) of the respondents, was 2-3 years in total, followed by "less than one year", reported by 18% (n=22) of our respondents. 17% of our respondents (n=20) reported staying abroad between 6-10 years. 13% of the respondents did not answer this question (Table 14).

		Frequency	Valid Percent
Valid	less than 1 year	22	18.3
	1 year	14	11.7
	2 - 3 years	31	25.8
	4 - 5 years	11	9.2
	6 - 10 years	20	16.7
	more than 10 years	7	5.8
	did not answer	15	12.5
	Total	120	100

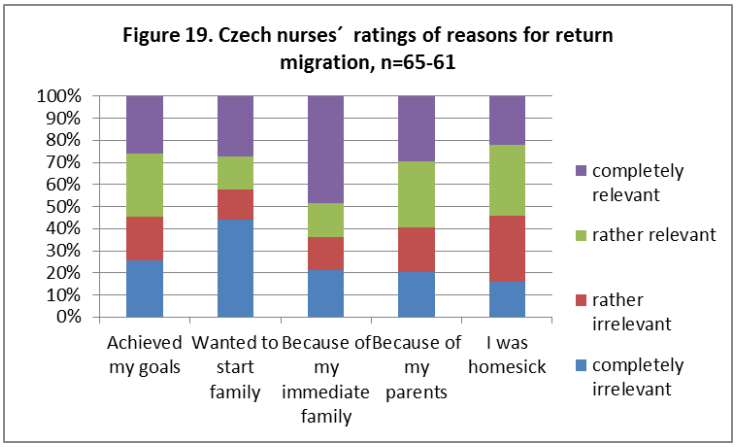
Table 14. The length of Czech nurses´ migration

The respondents appear to return to the Czech Republic in larger numbers if their length of migration is up to 3 years (Figure 18). After that, the proportion of respondents who have not returned increases (purple bar) and the amount of returning migrants decreases (blue bar). A total of 17 respondents were not included in Figure 18. (Four respondents selecting the category "other" and 13 respondents who "did not answer" in question 38.).



Question 39 explored the reasons for return to the Czech Republic. Within the subgroup of Czech nurses who returned to their home country (n=74), between 61 and 65 respondents rated some of the reasons for return migration. Some of the suggested reasons were rated by 65 respondents. The reasons “because of my parents” and “I was homesick” were rated by 63, and 61 respondents respectively. The respondents were asked to rate each given reason for return migration on a scale 1 - 4, based on their personal situation, “1” meant “completely irrelevant to my situation”, and “4” meant “completely relevant to my situation”.

For the majority of the respondents, the suggested reasons for return migration were similarly relevant (Figure 19.), the most important reason was “I returned because of my immediate family,” followed by “because of my parents.” In the open option “Other reasons for return migration,” four respondents stated that they did not enjoy living and working abroad and two respondents had to return because of their expiring visa in the destination country and to finish their education in the home country. The respondents did not indicate any further reasons for return migration. The item "I wanted to start a family" (n=65) received a "completely irrelevant" rating from the respondents in the age group 51-60 years (n=8) (Figure G1.19 in Appendix G1). Table G1.19 is in Appendix G1.



The vast majority (78%, n=91) of the respondents, the Czech migrating nurses, **did not report migrating repeatedly** (Table 15.) Those that did most often repeated their migration to Saudi Arabia (9%, n=11), which was also the most common destination country for our respondents. Only in a few cases did the respondents report migrating repeatedly to other countries. The performed cross tabulations did not show any other relevant trends.

			Responses	Percent of Cases
		N	Percent	
26_returned to any country recode[a]	not returned to any country	91	77.80%	77.80%
	yes, Germany	5	4.30%	4.30%
	yes, Austria	1	0.90%	0.90%
	yes, Saudi Arabia	11	9.40%	9.40%
	yes, USA	2	1,70%	1.70%
	yes, UK	3	2.60%	2.60%
	yes,other	3	2.60%	2.60%
	no comment	1	0.90%	0.90%
Total		117	100,00%	100,00%
Dichotomy group tabulated at value 1. Multiple answers possible.				

Table 15. Circular migration of Czech nurses

4.5.5 Research question 3: Can the experience of Czech nurses who migrate be described?

This research question was answered by respondents´ answers to questions Nos. 4, 9-18, and 36 of the SAQ.

Question 4 of the SAQ explored common problems with credentialing and finding an appropriate position abroad. *(Did you experience any difficulties when you were looking for work abroad as an RN?)* The respondents (from the RN subgroup, *n* = 83) could select multiple answers. In this study, 40% (n=41) of the Czech nurses seeking employment abroad as an RN stated that they did not experience any difficulties while looking for work as a registered nurse abroad. 27% (n=28) of the respondents felt that "the recognition of their qualification by the destination country took a long time" and 11% (n=11) had "other problems with their qualification." The category "qualification recognition by the destination country took a long time" did not contain any further specification of the time, and it was left up to interpretation by the respondents. 2% and 5% respectively reported problems with their employer and the recruiting agency (Figure 20).

Figure 20. Difficulties with finding employment abroad as an RN (n=103, multiple answers)

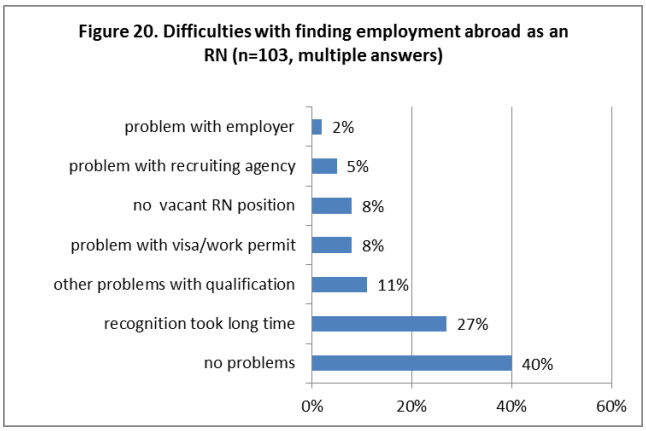
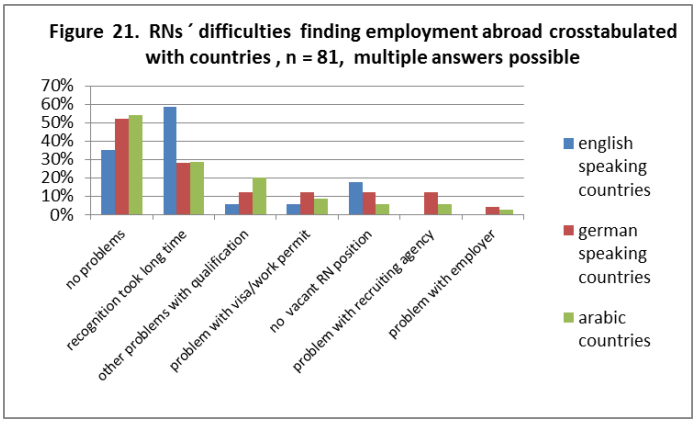


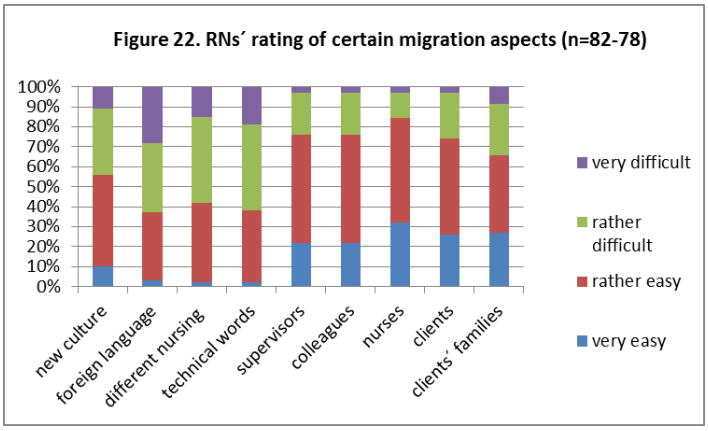
Figure 21[40] demonstrates that 60% (n=10) of the Czech nurses migrating as RNs to English speaking countries reported that the recognition procedure was lengthy. 30% (n=6) of the respondents migrating to English speaking countries did not experience any difficulties when looking for employment as an RN. Slightly over 50% of the RNs migrating to both German (n=13) speaking and Arabic (n=19) countries did not experience any difficulties when looking for employment. If they reported that they encountered problems, it was often a lengthy qualification recognition procedure (30% of respondents in both groups). These differences in experience based on the destination country are rather interesting and were therefore explored further in this study. Four respondents (migrating to "other country") were not included in this Figure in order to enhance the figure's clarity.



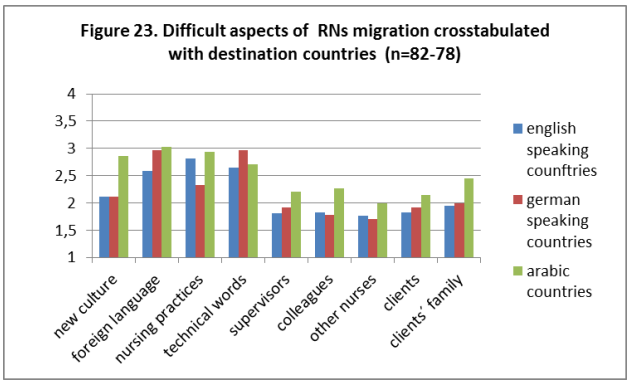
[40] The cross tabulations of difficulties experienced when looking for employment as an RN abroad with the highest obtained education or age at the time of their first migration did not show particularly interesting trends explaining the research questions; further, in the case of the highest obtained education, it is not clear from our data whether some of the education paths were completed before migration or later.

Question 9 assessed the initial difficulties at the workplace abroad which are well defined in the literature (*What did you find difficult about working abroad as a registered nurse? For each possibility, assign points according to how difficult it was for you.)* (Figure 22.) Within the subgroup of Czech nurses who worked abroad as RNs (*n* = 83) between 78 to 82 respondents rated some of the suggested items. "Adapting to a new culture" and "communication in a foreign language" were rated by 82 respondents. Only 78 respondents rated the item "the relationship with the clients´ family". The respondents were asked to rate the difficulty of each given aspect of migration on a scale 1 - 4, based on their personal situation, "1" meant "very easy in my situation", and "4" meant "very difficult in my situation".

Figure 22 describes the RNs' ratings of the suggested migration aspects expressed in percentages. The "foreign language", "different nursing practices" and "technical words and jargon in foreign language" items were "very" or "rather difficult" for 60% of the sample. On the other hand, the items exploring the relationships at work were "very" or "rather easy" for about 70% of the respondents. In the open option "Other difficult issues," one respondent stated that the other difficult issue was the administrative nursing tasks, one other respondent stated that another difficult issue was finding and keeping relationships other than work related ones. Apart from that, the Czech respondents did not relate any other difficult issues which had not been previously mentioned in literature. Table G1.22 is in Appendix G1.

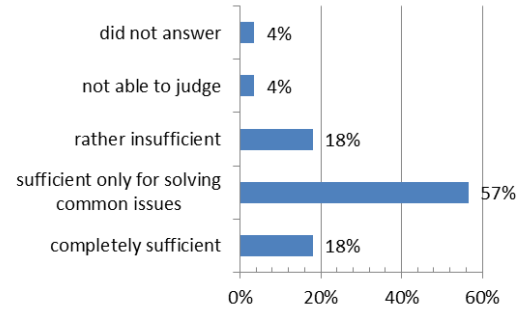


As demonstrated in Figure 23, the item “adapting to a new culture” was more often rated as “more difficult” by respondents from Arabic countries (mean=2,86) compared to English and German speaking countries, with a mean of 2.12. Also, the relationship items were consistently rated as slightly more difficult in Arabic countries. “The communication in foreign language” was more difficult for the respondents in German speaking and Arabic countries as compared with the English speaking countries. On the other hand, the “new work practices and the different approach to the nursing profession” was considered rather easy in German speaking countries as compared to English speaking and Arabic countries. Five respondents (migrating to “other country”) were not included in this Figure.



A sufficient command of the local language of the destination country was explored in Question 10. *(When you first started to work as a registered nurse abroad, your language abilities were…?).* Figure 24 shows that 18% of the Czech nurses who worked abroad as RNs felt that their language abilities were "completely sufficient - at work I communicated without a problem in all situations" n=15, while the majority 57% (n=47) reported that they were "sufficient for solving most common issues at work, but not for solving sensitive or difficult problems". Another 18% (n=15) selected the option "rather insufficient, I had problems communicating at work about common things". The cross tabulation of the language abilities and the destination countries did not show any additional interesting trends.

Figure 24. The self-evaluation of the Czech nurses proficiency in foreign language at their first RN job abroad, (n = 83)



Another typical obstacle described in many studies is the efficient transition of the internationally educated nurse into the host country nursing system. *(Question 11. After the "orientation period", which was intended for a smooth transition into your first nursing position abroad, you could work…?)* While 46% (n=38) of our respondents stated that after the orientation period, they "could work without a problem completely independently", another 47% of the respondents stated that they "could work independently with minor problems especially because of the different approach to nursing" and "could work independently with minor problems mostly because of the different language" (22.9%, n=19; 24.1%, n=20 respectively) (Figure 25). 2% of the respondents felt they were not ready to work independently after finishing the orientation period.

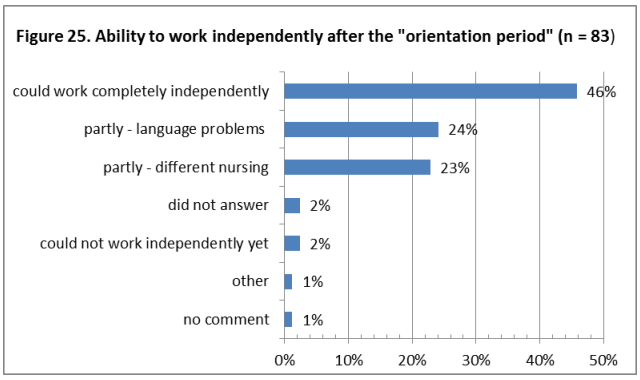
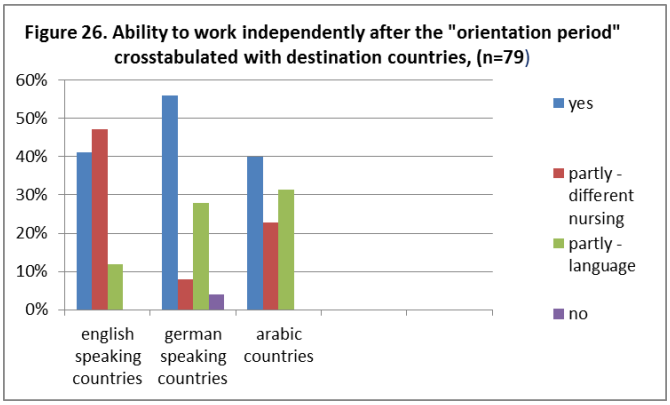
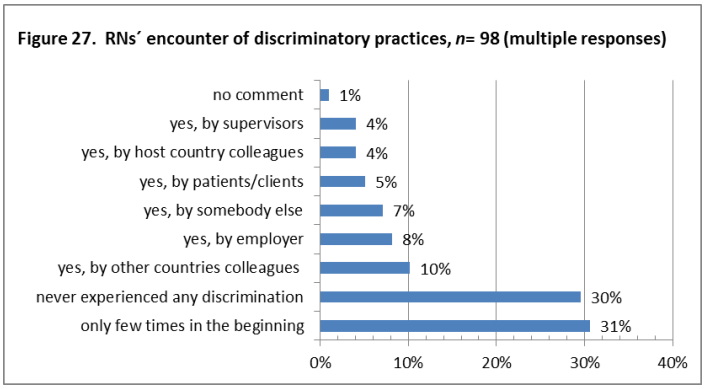


Figure 26 shows some interesting differences between the destination countries. 47% (n=8) of the respondents working in English speaking countries reported that after their first orientation period, they “could work independently with minor problems because of the different approach to nursing” and a similar number of nurses reported that they could work “completely independently.” Only 12% (n=2) from this group reported that they “could work independently with minor problems because of the different language.” The situation is very different in German speaking countries, where 56% (n=14) of the respondents “could work independently”, but only 8% (n=2) “could work independently with minor problems because of a different approach to nursing” and 28% (n=7) “because of the foreign language.” The answers from the respondents working in Arabic countries seem to be more evenly distributed. Ten respondents (not answering in question 11 or answering “no comment” and “I did not have any orientation period” “other countries” and “did not answer”) were not included in this Figure in order to enhance the figure’s clarity.



Based on the reviewed literature, it appears that migrating nurses sometimes do experience discrimination in the destination country. Question 14 of the SAQ explored this issue *(When you worked abroad as a nurse, did you experience any form of discrimination? (For example, isolating you, mocking your language abilities, offering unfair working conditions)*. While the sensitivity of this issue needs to be considered, 30% (n=29) of the Czech RNs in this study stated that they "never experienced any discrimination". 31% of our respondents felt discriminated against "only a few times in the beginning" (Figure 27.) The respondents indicated a total of 38 cases of discriminatory practices committed by various actors. Two respondents working in Arabic countries commented on the perceived positive discrimination of European nurses compared to Asian nurses. Multiple answers were possible.

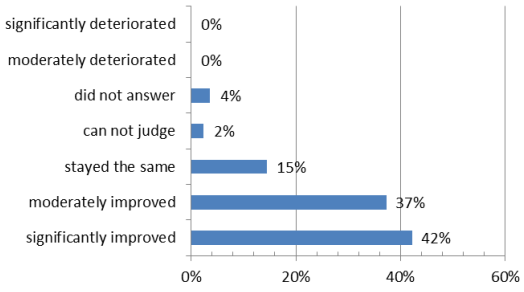
Figure 27. RNs´ encounter of discriminatory practices, *n*= 98 (multiple responses)



Another sensitive issue, that of possible workplace related abuse, was denied by the majority of Czech migrating registered nurses in this study; especially the Czech registered nurses working in English speaking countries overwhelmingly reported that they never experienced any kind of abuse, and this finding differs from that in other recently conducted studies (Jose, 2008), (Newton et al., 2012), (Moyce et al., 2015).

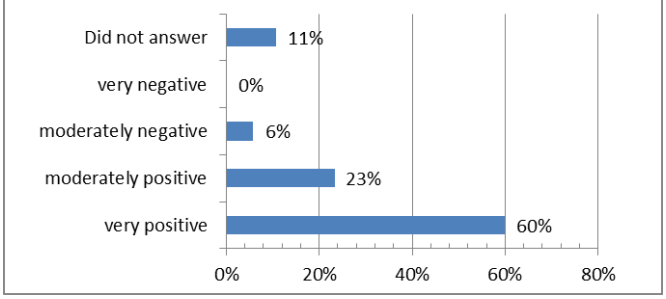
The influence of migration on professional nursing skills is well described in the literature. The studies often report a decline of the skills of the migrating nurse. Question No. 18 *(While working abroad my professional knowledge and skills…)* explored this issue. Figure 28 presents the answers to the above statement. 79% (n=66) of the Czech migrating RNs stated that their professional skills and knowledge "improved significantly" (42%, n=35) or "improved moderately" (37%, n=31) after their migration. Another 15% (n=12) believed that their skills and knowledge stayed at the same level. None of the respondents indicated skill/knowledge deterioration. The performed cross tabulations between the migration's influence on knowledge and skills and the destination country did not show any interesting trends.

Figure 28. The influence of migration on RNs´ nursing knowledge and skills, n=83



In Question 36 *(How would you rate your work experience abroad in general?)* 60% (n=72) of the respondents rated migration as a "very positive experience", 23% (n=28) reported "moderately positive experience", 6% (n=7) selected the option "moderately negative experience" and no one selected the option "very negative experience" (Figure 29).

Figure 29. Czech nurses´ evaluation of the migration experience, N=120

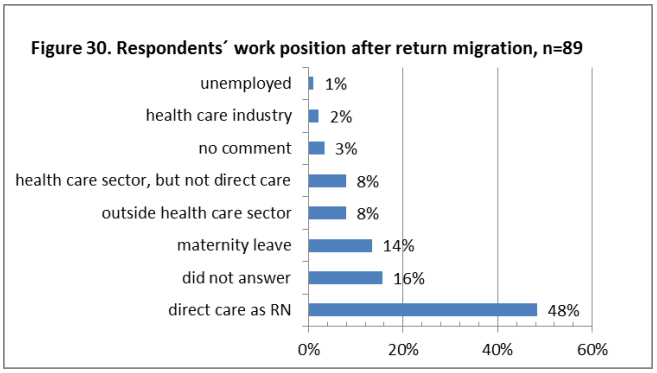


Czech migrants working as registered nurses in English speaking countries most often rated their migration as a very positive experience (Figure 36.2 in Appendix G1). Even though the absolute numbers are small, younger nurses seemed more satisfied with their migration than older nurses (Figure 36.1 in Appendix G1). The cross tabulations did not show any relevant trends.

4.5.6 Research question 3.1. : What is the impact of the Czech nurses´ migration on the Czech health care system?

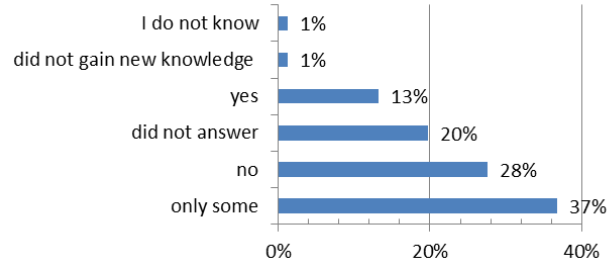
This research question was answered in questions Nos. 40-43 of the SAQ.

The impact of the return migration on the source country was assessed in question No. 40. *(Where do you work after having returned to the CR?)* Figure 30 displays the answers of the 89 respondents who were prompted to answer this question (out of the 120 total respondents). The largest group of the returnees (48%, n=43) worked at the time of the survey in the CR "as a RN in direct patient care." 14% (n=12) of the respondents were on "maternity leave." 8% (n=7) of the respondents worked in the Czech health care sector in managerial or teaching positions. Similarly, 8% of the Czech nurses had left the health care sector and 2% worked for the health care industry (e.g. pharmaceutical, insurance company). The performed cross tabulations did not show any additional interesting results.



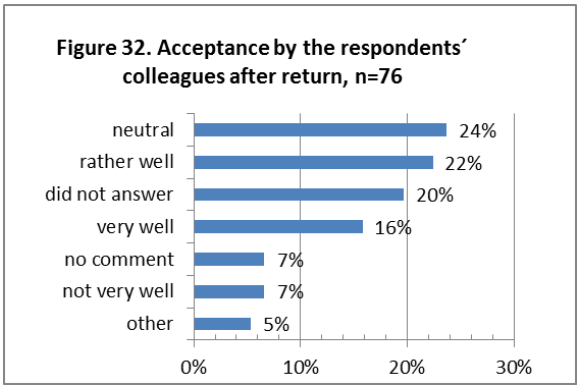
The majority of the migrating nurses returned to the Czech Republic (74 out of 120) and 80% of the RNs felt that after migration they possessed better professional skills and knowledge; therefore it is important to explore if the new skills could be transferred into Czech nursing *(Question 41. Do you think that you use the knowledge, which you gained abroad, in your current job in the CR?).* Figure 31 demonstrates the respondents´ opinion about being able to utilize the relevant knowledge gained abroad in their current position in the CR. From the 76 respondents who could access this question (12 respondents were on maternity leave and 1 was unemployed, Figure 31), 13% (n=10) reported they can use their new knowledge in their current position, 37% (n=28) reported they can use only some of the knowledge gained during migration and 28% (n=21) reported they are not using this knowledge in their current work position.

Figure 31. Usage of the knowledge gained abroad in the respondents´ current work position, n =76



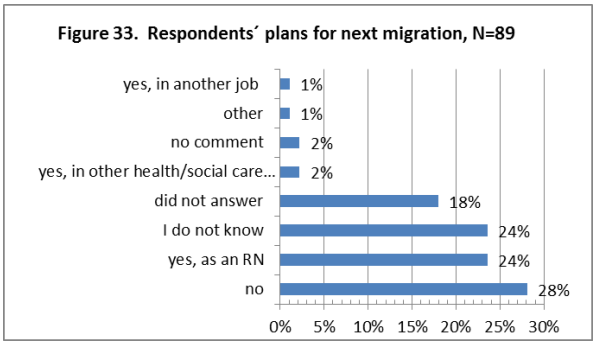
When cross tabulating the returnees current work position with their perceived ability to use the knowledge gained abroad in their daily work, within the largest subgroup of the respondents working in direct patient care as RNs (n=43), 7% (n=3) answered that they use their knowledge gained abroad in their current job. 46.5% (n=20) uses only some of the knowledge and 39.5% (n=17) does not use the knowledge in their current job. Therefore, **the new knowledge and skills gained by the nurses abroad did not seem fully utilized in the CR according to the experience of 86% (n=37) of these respondents.** Three respondents selected a different answer or did not answer. The other performed cross tabulations did not show any other relevant results.

As shown in Figure 32, the Czech respondents returning after their migration to work back in the home country were accepted by their colleagues “well” (38%, n=29; obtained by combining items “very well” 16%, n=12 and “rather well” 22%, n=17) and “neutrally” (24%, n=18). 7% (n=5) of our respondents were not accepted very well. Four respondents stated in the category "other" that after their migration, they did not return to work in the same facility *(Question 42. How were you accepted by your colleagues at work after you returned?)*



These questions were among the last items of the questionnaire; there is a noticeable increase in the “did not answer” category for these later questions, which may be anticipated, as they came towards the end of a questionnaire (Reichel, 2010).

The respondents´ plans for another migration were explored in Question 43 *(Are you thinking about leaving the CR again?)* As demonstrated in the Figure 33, at the time of completing the survey, 28% (n=25) of my respondents were not planning on working abroad again. However, a similar number reported that they had such plans (24%, n= 21) and another 24% “did not know.” 24% (n=16) did not answer to this question.



4.5.7 Research question 4: Can an assessment of the number of Czech nurses who migrate but are not employed in the destination country as nurses responsible for general care be made?

This research question was answered by respondents´ answers to questions Nos. 20-25 of the SAQ.

As demonstrated in the literature (Buchan and Aiken, 2008a), (Haour-Knipe and Davies, 2008), it is very difficult to obtain information on the group of qualified nurses who migrate and live in the destination country working in other professions, jobs or roles, but not as RNs. If these roles do not require "a registration" with a professional body (such as a register of nurses) these migrants cannot be practically tracked. Other general registers (for health and social insurance purposes – e.g. Work Registration Scheme in the UK - might cover some of these migrants working legally and officially in the destination country, but they will not easily share details on their actual qualification. The group of migrants working outside of official employment (e.g. numerous Eastern-European nurses working as private caregivers in client's homes in western EU countries) will not be included in any statistics. In our sample, only 37 qualified Czech general care nurses who migrated and worked abroad in professions other than as registered nurses replied to this survey. I discovered that it is not easy to target this group of respondents.

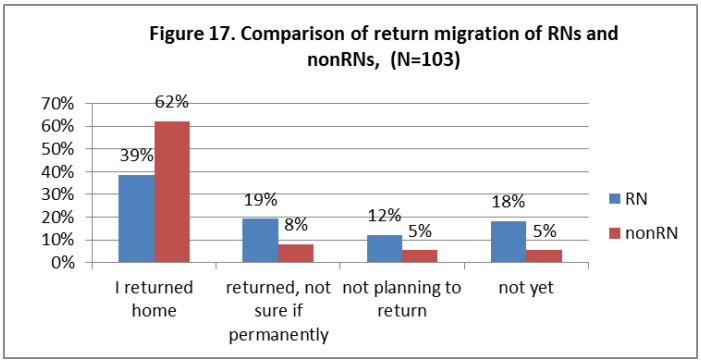
From the sub-group of the 37 respondents who reported **not working abroad as RNs**, 19 respondents worked in a health or social care profession (for example as a health care assistant, nursing assistant, aide, caregivers, personal assistant, or with people with special needs). 16 respondents from the non-RN group worked abroad in other professions unrelated to health or social care (for example as a nanny, waitress, cleaner, in a shop, office, or factory). Two respondents did not reply to this question.

Table 10 shows that the respondents who worked abroad as non-RNs migrated mostly to the UK (32%, n=12), and to Germany (27%, n=10). Six respondents in total (16%) migrated to the following "other country": Two respondents to Australia, and one respondent each to Switzerland, Israel, France, and the Netherlands. Four respondents migrated to the USA. One respondent each migrated to Ireland and to Austria. Eight percent (n=3) of the respondents left this information blank in the questionnaire.

		Frequency	Valid Percent
Valid	Ireland	1	2.7
	Germany	10	27
	Austria	1	2.7
	USA	4	10.8
	UK	12	32.4
	other country	6	16.2
	did not answer	3	8.1
	Total	37	100
Missing	99	83	
Total		120	

Table 10. Destination countries for Czech nurses working in other professions (non-RNs)

Figure 17 shows that while 39% (n=32) of the Czech nurses working abroad as RNs returned home after a period of migration, 62% (n=23) of the nurses working abroad as non-RNs returned to the home country.



Within the subgroup of Czech nurses who worked abroad as non-RNs (n=37) (i.e. in professions other than as registered nurses) between 27 and 32 respondents rated some of the reasons for their migration. The respondents were asked to rate each given reason for migration on a scale 1 - 4, based on their personal situation, "1" meant "completely irrelevant to my situation," and "4" meant "completely relevant to my situation." The results are similar to those of the RNs subgroup, the most relevant item being the improvement of their language abilities and with the items "economic improvement" ranking second and "life experience" ranking third, thus switching places in comparison with the RNs' results.

As seen in Table 16, twenty respondents out of the thirty-seven replied to the question about the recognition of their qualification. Fourteen Czech nurses working abroad in a non-RN profession applied in the destination country to have their Czech RN qualification recognized. From this group, four qualifications were recognized, two respondents were waiting for the result at the time of this survey and eight qualifications of Czech RNs were not recognized by the destination country (three in the USA, two in Germany, two in the UK, one in Austria). Six Czech nurses working abroad in a non-RN profession did not apply for recognition of their qualification for various reasons.

	I applied, was accepted	I applied, was not accepted	I applied, waiting for results	Did not apply, it takes a long time	Did not apply, language reasons	Did not apply, I am not interested
Ireland	1					
Germany	1	2		1	2	
Austria		1				1
the USA		3				
the UK	1	2	2			1
Other country	1				1	

Table 16. Did you apply to have your qualification recognized so that you could work as a nurse responsible for general care (registered nurse)? (n=37)

4.6 Findings from the third qualitative strand

The next section presents the results of the **third qualitative strand** of this study, in which I conducted three mini-focus groups with the migrating Czech nurses in order to explore the findings from the previous strands in detail and answer the research questions in more depth. Here I present the developed codes and themes, the illustrating narratives and the researcher´s comments. A deeper analysis and interpretation of the qualitative data (what is interesting about these data and why) is presented in Chapter 5 - Discussion. An analysis of such data should not just paraphrase the statements of the participants but should aim at pointing out their different meanings and interesting relationships as well as their presumed reasons. The role of the researcher is to "look behind the data" (Braun and Clarke, 2013). Similarly, Gibbs (2008) advises the researcher to ask "what is going on here" in this transcript and asks to go beyond a description of their data. Table 17 below describes the used notation system in transcripts.

"..."	indicates a pause in the participant´s speech, the more periods, the longer pause.
Ahaaaa	indicates stress on a certain word
(laughs)	Indicates an important paralinguistic feature, which is described in the parentheses
Doctors without borders	Indicates a name of an organization
…	Participant continued speaking, but I did not include it, because it was not relevant
/…/	I omitted some words from participants statement which were not relevant
/in Saudi Arabia/	I explained participant´s comment

Table 17. Notation system used in transcripts

The themes and codes identified during the analysis of the third qualitative strand are listed below in Table 18. After that, I present each code and the supporting excerpts from the statements of the focus groups´ participants.

	Themes		**Codes**
Theme 1	**Coping with discrimination in some countries**	1	Financial inequality in Saudi
		2	Presence of discrimination in Saudi
		3	Career opportunity abroad possible if you stay long enough
Theme 2	**Missing professionalism**	1	Professional nursing behavior versus task orientation
		2	Nurses abroad are more independent
		3	Medication safety
		4	Palliative care is more advanced abroad
		5	Transformation
		6	Other professions to support nurses
		7	Relationships at workplace
Theme 3	**Circle of leaving and returning**	1	Abstract wish to learn a language
		2	Money as a pull or just an extra bonus?
		3	Wish to experience something different
		4	European values as a pull back
		5	Czechs migrate temporarily unless…
		6	Health care systems abroad work more efficiently
		7	The Czech health care has little interest in innovations

Table 18. Codes and themes resulting from the qualitative strand

4.6.1 Theme 1. Coping with discrimination in some countries, Code: Financial inequality in Saudi

The participants in all three groups agreed that financial discrimination is present in Saudi Arabia, and that paying different wages based on a workers´ nationality for the same work is very problematic.

> *N8: Different nationalities are paid differently for the same work, it´s a big problem,*
>
> *N1: Big discrimination is present in Saudi, actually they pay the staff based on their country of origin,*

However, such a system is the norm in Saudi Arabia

> *N5: …but that´s the way they do it in Saudi,*
>
> *N2: They probably don´t mind /the discrimination/ because they go there…*

One participant believed that the system where everybody is paid differently based on her/his wage in the home country, while discriminatory, makes certain sense, saves resources and is only possible because people come to make money to Saudi Arabia and then bring it back to their country of origin.

> *N1: …Because they don´t want to live there, because if they wanted to live there and I had three times higher wage than my colleague, there would be bigger problems, but since people are there only temporarily, to make money and return home…*

This system where everybody is paid a multiple of the average wage which they receive in their home country serves as a major pull factor for everybody, including the Czech nurses.

At the same time, the system in Saudi Arabia was seen as flexible, as demonstrated by:

> *N4: After the Czech Republic entered the EU we wrote a letter to the management that we are EU citizens and we want to be paid as EU citizens. All of my colleagues - native speakers, supported me on this, and it was a very positive experience. After this, all of the Czechs were offered higher wages.*

4.6.2 Theme 1. Coping with discrimination in some countries, Code: Presence of discrimination in Saudi

According to the participants, discriminatory practices are quite common and diverse in Saudi Arabia, performed by various actors, aimed at different targets. On the other hand, according to the participants who worked in other destination countries, discrimination was not present in any of these destination countries.

The participants suggested that the Filipino nurses need the work in Saudi Arabia more urgently and therefore are willing to accept worse conditions than some other nurses, including the Czech ones:

> *N1: …Now I exaggerate, but if they asked a Filipino nurse to jump out of the window, she would…,*
>
> *N8: …They are missing some basic self-esteem, they go like: 'Yes, sir' /mimicking bowing down/*

The higher assertiveness of Czech nurses was not related to gender according to N1, but was based culturally, and stemmed from the fact that they were not dependent on the income from Saudi Arabia.

> *N1: I think that yes /Czech female nurses will assert their rights too/ the Czech nurses simply have such an attitude.*

Also, some participants felt that the Filipino nurses were reprimanded more than the other internationally educated nurses in Saudi Arabia for the same mistakes, and they were therefore cautious and afraid. The respect among the colleagues in Saudi was to a certain extent based on their nationality.

> *N10: …When somebody with a fair complexion made a mistake, it was not a big deal, but if it was a Filipino, it was a problem and a big one,*
>
> *N7: …I did not flush the line, the physician said: ´Flush it then!´ but if such a mistake was made by a Filipino, then (…), well (…), uff…,*
>
> *Nx: Who knows how many Filipino nurses ended up in the desert…*

According to one participant, the fact that stricter rules applied to Filipino nurses probably originated in the past, when people from the Philippines worked in Saudi only as domestic staff. Two participants commented on a gender issue – the status of women in the

Philippines, and that it is probably different than that in Eastern Europe, but one which has a surprisingly similar outcome – lower self-esteem:

> *N7: Yes, it is from the past, like the servants, it is some kind of complex, maybe like what we have*

One participant added that in her ICU unit in Saudi, Filipino nurses were excellent nurses and were completely respected by everybody, another participant added that Filipino nurses in the USA are very confident.

All participants who worked in countries other than in Saudi Arabia reported that they did not notice any kind of discrimination in their workplace.

> *N3: I didn´t experience that, and also those nurses I know didn't experience it*
>
> *N6: Definitely not from the staff, it is not common in England.*

Four (out of six nurses in the qualitative part of this study who worked in Saudi Arabia) reported some discriminatory practices observed in Saudi Arabia, often early after their arrival. It was also related to their weaker command of English:

> *N4: The beginning was quite hard, before I understood all of the accents in our unit, not from the patients, but from my colleagues, from the native speakers, when I did not understand everything what´s going on, what they want from me.*
>
> *N8: I experienced serious harassment, I did not speak the language and I did not have much experience as a nurse. I was told: ´you are stupid and you get more money´*
>
> *N1: …they spoke Tagalog. Everybody complained about it, I also did not like it /…/ it is really unpleasant when around you your colleagues speak a different language, not only about their things, but also when they spoke about professional things around patients.*

Two participants reported that they felt disrespected when the local staff made assumptions about the living conditions in the Czech Republic.

N6: I couldn't stand that they didn't know that we are a member of the EU, and at that point we had been for a long time, and that they did not know the situation in our country, somebody would ask if we have roads… (N5 agrees)

Participants in group 3 then unanimously agreed that discrimination is related to the individual's language skills level:

N7: you know what, actually, if somebody comes to the Czech Republic and would not speak Czech, he could have a college degree and we would look at him like, you don't speak Czech - then you are stupid N10: …It is about the language a lot (everybody agrees)

One nurse reported positive discrimination of Czech nurses by the patients in Saudi

N5: …and from the patients, I think if somebody is a nurse with white skin,that is more like a huge benefit. They perceive very positively that they are cared for by a blond nurse with blue eyes…

This opinion appeared at least three times in the quantitative strand of this study as well.

4.6.3 Theme 1. Coping with discrimination in some countries, Code: Career opportunity abroad possible if you stay long enough

Participants in all groups regardless of their destination country almost unanimously agreed that there are no boundaries to career progression abroad, definitely not any related to the original nationality of the nurse. Respect for the abilities of the aspiring nurse is demonstrated in the first narrative:

N5: …There is huge fluctuation of nurses and because of that the career opportunities are huge and I would say for everybody the same /…/ If the person is skilled, they detect that that he is able, the career progression is almost unlimited (N4, N7, N9, N10 agree)

Theoretically, the relatively easy career path can be a pull factor for Czech nurses; however, the participants in this study did not address this issue directly.

The only necessary conditions are that the nurse stays abroad longer and masters the language to almost a native speaker level. Again, N3 speaks about the fact that the nurse´s abilities are respected by the managers.

N1: The career progression is possible but after some time spent abroad and Czech nurses do not stay that long

N3: …In many managerial positions there were foreigners, mainly German speaking, or from India, they studied in Austria and had grammar school and the other schools, their language skills were really on native speaker level. Also I would say that this was very open there /…/ basically if they saw that she is professionally or organizationally able, she could go further and it was not dependent on the nationality"

Even though some previously conducted studies suggest less fair treatment of foreign educated nurses (Newton et al., 2012), (Moyce et al., 2015), in some countries, while a career progression was still very possible and viewed as fair by the participant in the study, mainly the native colleagues navigated through the system and assumed the managerial and higher positions. Also, one of the few occasions when the participants mentioned a gender related issue was in this narrative:

N6: I think in the managerial positions, managers and also nurses, there I noticed only English women and men, quite a lot of men as managers, but the Indian and Filipino nurses were starting, but I haven´t seen anybody from Europe, there is the equal opportunity, so everybody gets what he wants, but I think the Brits know the way the best…

4.6.4 Theme 2 Missing professionalism, Code: Professional nursing behavior versus task orientation

The participants listed various aspects of nursing professionalism, which was perceived as more developed abroad and less developed in the Czech Republic; they also commented on the lower prestige of the profession in the Czech Republic.

N6: What is missing in a Czech nurse is professionalism, when a Czech nurse is in a bad mood, everybody knows it, when a British nurse is in a bad mood, nobody notices.

The participants believed that the lower professionalism was caused by the fact the Czech nursing concentrates on practicing and evaluating the performance of single procedures and not so much on complex professional nursing behavior. N8 is transformed by her

migration and is able to distinguish between different priority tasks, moreover she is able to justify and defend her decision.

> *N4: Because we are evaluated for performing a single procedure not for /professional/ behavior*
>
> *N8: …I don't do so many overtimes, I concentrate on quality not quantity, but Filipinos see it like this: ´it´s been said that the cans are being counted now – lets count the cans.´ And I don´t count the cans, I say ´girls, I am not counting cans now´*

The participant N4 shared that she perceives nursing as a prestigious and attractive profession. According to her, her perception is probably influenced by working abroad with professionals who were proud to be nurses. In this narrative she really speaks about being transformed, and now understanding nursing differently than is typical for a Czech nurse:

> *N4: I think that you bring back a lot of things, for instance after all of these years I am not completely burned out, I think it is because I worked for years with people who are proud to be nurses, we don't have many of such nurses, it is not only about the language, I personally feel, that I brought back that I perceive the profession slightly differently than how it is perceived here.*

According to the participants the Czech nurses are not sufficiently empathic because they never consciously experienced and explored the possible feelings of a patient.

> *Nx: How would I like it if I were here and the key owners passed around me with cup of coffee in their hand. (This nurse worked in a less acute care unit)*

During her orientation period practical workshop on care for patients with dementia **abroad,** N3 personally experienced the feelings of patients who were fed by somebody not sufficiently empathic, and now she consciously uses similar experiential and transformative learning in her lessons with her nursing students.

Some participants in group three explicitly mentioned that Czech nurses do not consider their patients to be their partners and they act superiorly towards the patients.

> *N9: Here /in the Czech Republic/ I miss a positive attitude towards the patient*
>
> *N8: Yes, and patience and kindness. N7: Definitely not to be bossy*

Similarly, one participant stated that professional communication is not sufficiently practiced during the Czech qualification education.

> *N4: Our education concentrates on passive lectures in classrooms, we miss practical workshops in communication, so the people can try how they feel in it*.

According to some participants, the non-existence of an "expected nursing professional behavior" is causing many Czech nurses to accept certain menial jobs as their main role and they do not recognize that professional behavior should be a priority.

> *N7: I feel that many of our nurses cause this, that people look down upon them, they are considered girls for everything, it is a question of certain level, some nurses are stuck on counting garbage cans in the halls, there are six and should be seven, she wastes lots of energy on this task and she should be solving problems with IV line infiltrating, or somebody's low blood pressure…,*
>
> *N10: …the /Czech/ nurse took the pill, told me that they don't have the crusher, so she crushed it between her own teeth that was something!!! (Everybody expresses surprise) that it doesn´t need to be sterile. My eyes almost fell out of my sockets /after return migration in a Czech hospital/.*

An active participation in CPD, which is a norm in Saudi Arabia, would not be accepted by many Czech nurses, however the nurses who were transformed by migration strongly believed in it.

> *N10: it was very positive in Saudi, and if I transferred it to Czech health care, I felt I would be laughed at by many Czech nurses N8: Yes, they would laugh at us N10: You try and want to do it properly, you want to know what you are doing, learn what it is connected with, but you are the thorn in the eye, that is demotivating, but it is not about being an overachiever, I just want to know what am I doing…*

The CPD activities abroad are more specific to the concrete needs of nurses in different types of units, which results in better continuity of care.

N6: The CPD courses were tailored to the needs of the nurses in each unit, ICU nurses had ventilation, IV meds, positioning of patients, BLS, etc. Here, we have courses where everybody can go, but it is not exactly for my specialization.

N4: The nurse mentors taught students, new nurses and also normal, other staff in new procedures and everybody did certain procedures the same way then because it came from one person.

What followed was a discussion whether there are nurse-mentors in the Czech Republic and what they do. The CPD system abroad was viewed positively by the participants, and the standards of nursing care were described as more helpful and meaningful than those in the Czech Republic.

N5: Refreshing our knowledge, every two years we had to pass an exam – BLS, hand hygiene, to confirm that you know how, that you follow the standards of care.

N9 commented on the heavy workload in the Czech Republic and also in the USA, with the difference that the nurses´ work was more "skilled" in the USA, thus more rewarding, meaningful, valued and respected by the patients, doctors, colleagues.

N9: …I perceive it as a different kind of exhaustion than here, the work was recognized by many people and was giving me a lot.

Some participants in two groups spoke about the differences in communication within the health care team abroad and in the Czech Republic, suggesting that more open and efficient communication takes place abroad, where nurses´ professional skills are more respected by their colleagues.

N5: The nurses were not afraid to talk to the physicians and their nursing comments were taken very seriously

N8: …The resident says: ´I cannot order this painkiller or antiemetic´, /I tell him: /´Call somebody, the patient is oncology patient and you know it, this is not possible´ and I argue and my boss tells me: ´you can´t do this´ and I say: ´Yes, I can´

N9: The resident wanted us to do something, but it was not in our competence, and the nurses defended this very well and said: ´no, doctor, we cannot do this, YOU have to do this´

4.6.5 Theme 2 Missing professionalism, Code: Nurses abroad are more independent

There was almost unanimous agreement among the participants in all three groups regardless of their destination country that the competences and independence of nurses are higher abroad than in the Czech Republic. This was considered largely as beneficial, because it can "liberate" nurses and bring more responsibility and less carelessness into the system. The higher competences would transform the nurses to a certain extent.

N10: …Higher competences, higher responsibilities, it liberates the nurses in a certain way, they are more independent, I think, they are not these beings which are moving there and back and wait that the doctor will say this or that…,

N9: With competences would come the responsibility and there would be less carelessness,

N5: The nurse there is very independent in evaluating the patients, for example the physical examination, I haven´t seen here, that the nurse would check the patient from head to toes and then make a nursing diagnoses.

The last narrative demonstrates the differences in nursing competences in both countries, which the "transformed" participant automatically expects also in the home country.

One participant noted that more competences mean more work and therefore more staff to cover all of the work.

Abroad, unlike in the Czech Republic, it is common that the competences of different types of staff are clearly defined based on the obtained education, they are respected and strictly followed. Simply replacing the nurses by a less educated workforce demonstrates a lack of respect for the nurses by their managers.

N9: …after I passed the NCLEx[41], I told my boss, I worked in this unit before as a private caregiver, I told my boss that I don't know if I manage as a RN so suddenly, and he told me: ´When you have NCLEx then you are a nurse´, he perceived it, he took it as given, that if I had passed the exam, he doesn´t expect any problems and obstacles, so it is connected with the education and the license

N4: Here, sometimes the orderly is an important person in charge (laughs)

The official competences and independence of nurses in the Czech Republic as described in the current law, seem to be "lower" when compared with the western world, and it prevents the returning nurses from working as bedside nurses in the Czech Republic again.

N9: …I did not find what I was looking for, what I was used to, the competences and independence, decision making, possibility to help...

One participant (N7) questioned whether all Czech nurses are ready for higher competences.

N7: lets look at (…) the pill /nurse crushing a pill between her own teeth/ such a nurse cannot want more competences, at this level" N9: "but this is sheer ignorance, they don't realize at all what they are doing

This respondent also reported that sometimes the nurses were given very extensive competences in Saudi Arabia. N10 opposed this statement:

N10: I believe that it was beneficial for nurses, I don´t feel that we did something (…), nobody wanted me to insert a central venous cath or something like that.

*S*ome respondents mentioned that Czech nurses are valued in Saudi Arabia for their good care of the patients, especially caring for their physical needs.

N5: I know that Czech nurses are very much liked there, but they are known not to have good language skills, so the employer looks at them slightly

[41] NCLEx is a licensing examination for (registered) nurses in the USA. Every nurse has to pass this exam in order to practice the profession immediately after gaining qualification or as a part of the credentialing procedure (in the case of internationally educated nurses)

carefully, but when they learn how to speak they are considered to be very good.

According to N6, nurses in the UK participate in advanced tasks such as being members of the outreach team or follow up clinics for patients who recovered from a long-term ICU stay. These skills could be transferred to the Czech system too. The possibility to learn something new what can eventually be useful for the Czech system came up in many comments. Some participants mentioned that this pull factor – to "learn something new and bring it back" - was important for them personally.

4.6.6 Theme 2 Missing professionalism, Code: Medication safety

Issues surrounding medication administration were mentioned by the participants in two groups, they recommended some points which would be useful in the Czech nursing practice. Among these were compulsory double checks of certain medications by two nurses, and checking the dosages before the nurse administers certain medications; as well as more knowledge in pharmacology (mentioned by three participants).

N10: I would say the double check of medication, it was very good

N9: It was our professional responsibility to check the dosages, and it happened to me once that the doctor mistakenly increased the dose by a decimal point.

The participants viewed the system of administering medication to patients abroad as better managed than in the Czech Republic. Even though it was acknowledged to be more demanding on the workforce, they still saw clear benefits to it.

There were opposing opinions from three participants from Saudi Arabia as to whether the nurse had to ask the doctors to order medication properly. Two respondents who worked on a standard floor and a procedure lab believed that the nurses had to "play the doctor," another respondent who worked in an ICU did not have such an experience.

4.6.7 Theme 2 Missing professionalism, Code: Palliative care is more advanced

Participants in two groups who worked in Saudi Arabia and in Switzerland were both very enthusiastic about transferring the host country approach to palliative care and care for dying people and their family to the Czech Republic, because they felt that our system can learn from the sensitive approach to dying in both destination countries. The human dimension when encountering death even wiped away any gender restrictions in Saudi Arabia.

> *N3: The palliative care is much further there, both the care for the dying person and the care for his family. The contact is not comparable. I came and they kind of expressed that they /the employer/ value my professional skills, I thought that I am surely better educated, but I was really ashamed about the palliative care…*
>
> *N8: The mother died, the 10 year old boy was crying, I hugged him and gave him my food, it is my cup of tea /…/ I hug men as well, they also cry on my shoulder"/in Saudi Arabia/,*
>
> *N10: I agree, there is not this distance, at least in the hospital, they are in beds and they are very sick…" /in Saudi Arabia/,*

The participants believed that the Czech nurses are currently not used to supporting the dying and their families. The Swiss system showed appreciation for certain skills or knowledge of the migrant nurse, although some of her other skills (in palliative care) were not as advanced.

4.6.8 Theme 2 Missing professionalism, Code: Transformation

The migrating nurses in this study were transformed by the act of migration in many aspects, mainly professionally, but also personally. The issue of transformation is present in many other narratives in other codes. The participants wished to utilize their newly gained skills back home, but they were very aware of the limiting factors.

> *N8: I learned something there and I hope I can use it over here /in the Czech Republic/ too, but maybe not*

They weighed the pros and cons of adjusting to the Czech system against the wish to use their new skills, and then decided what the breaking point was which they would not want to cross. For some of the (transformed) participants, the perceived need to lower their standards after they would return to the Czech health care system meant that they opted not to return to Czech clinical nursing at all.

> *N8: It is wrong /to lower my own standards/, it is better to work as a receptionist in a hotel, I thought, but I feel it's a real pity*
>
> *N10: …Well I didn't expect much, but this…/crushing the pill in the nurse´s mouth/, there were more moments like this /after returning to a Czech hospital/, when you just wonder what is just too much, and what is like – ok, maybe; but what you don't want be a part of*
>
> *N9: I tried to work at least one day per week in a hospital /after returning to the Czech Republic/ I wanted to transfer what I learned, but it collided and I left the unit after one year and never worked shifts again*

Some participants in two of the groups spoke about how migration opened new unexpected horizons for them.

> *N6: First you go there to learn the language, then, I feel, you get a completely different view on life and different, like - here we are enclosed and as soon as we left, new gates opened in front of us, and one gets different priorities, sees everything <u>differently</u> than in the Czech Republic and reconsiders what´s next...,*

4.6.9 Theme 2 Missing professionalism, Code: Other professions to support nurses

Many participants in all three groups agreed that the multidisciplinary team abroad is composed of many more health care professionals, and that they work efficiently together. They viewed this as beneficial, because the nurses could concentrate on more skilled tasks or on their narrowly specialized tasks.

> *Nx: The nurses were very narrowly specialized in their field and they were very good in this field, for example, there was a psychiatric patient in an infection*

department, the nurses from the infection department were there for her somatic problems and the psychiatric nurses were there for her mental status.

N8 did not agree with the statement "*nurses do only skilled tasks in Saudi*"

N8: Jee, not at all! You do everything, washing patients, changing bed sheets

The group went on to discuss the definition of a "skilled task."

Abroad, even the helping staff was systematically and appropriately educated so they could provide the best care.

N3: The assistants and caregivers were trained to take care of the dementia patients, they knew how to handle the people, and they followed the concepts.

The other members of the team, such respiratory therapists and IV nurses, were mentioned by the participants, as these professionals carry out some of the competences which are typically performed by nurses in the Czech Republic. The number of staff members present in shifts was also viewed as higher abroad than in the Czech Republic.

4.6.10 Theme 2 Missing professionalism, Code: Relationships at workplace

All three groups mentioned this issue in their discussion. According to the participants, the relationships at the workplace abroad were better than in the Czech Republic. N4 and N10 described a lack of respect among colleagues in the Czech Republic in their narratives, while N6 and N9 worked abroad in a respectful environment:

N6: They are polite to each other and among the colleagues also, they act professionally, everybody is in a good mood

N4: It is like a chain reaction, if the nurses are treated badly by their bosses and the doctor yells at her and treats her as a servant, then the nurses are unpleasant and grumpy

N9: Yes the human atmosphere at workplace abroad! N7: Yes, /…/ you are knocked to your knees, if you don´t expect the (…), I will say it, envy.

The participants in a few groups stressed that it would be beneficial if all of the health care professionals could experience a system abroad, and that it would then contribute to their positive transformation:

N5: if the nurses had to, if it was a part of their education, to see the work somewhere else, in a different culture, it is very enriching

As identified in the Jose (2008) study, time was an important factor in the transformation of some participants:

N8: After I overcame /the discrimination in the beginning/ it is ok now, they see that I am reliable, they know that I work on a certain level…

For some, time influenced the plans to return to the home country:

N5: The longer you are gone the worse the return is.

N7 was wondering why colleagues react negatively to information about somebody's migration. She concluded that some people would like to migrate also, but for various reasons they cannot achieve it and it makes them envious.

4.6.11 Theme 3 Circle of leaving and returning, Code: Abstract wish to learn a language

The participants from all three groups only partly agreed with the statement: "A common reason for the migration of Czech nurses is the improvement of their foreign language skills." They offered some clarifications and explanations of this extensive topic.

Firstly, the participants believed that the migrating nurses have to possess language skills on a certain level even before they migrate, but for some participants the improvement of their language skills was the main motivator:

N1: Migrating nurses need to have some language skills, because otherwise they would not get a contract.

N4: I completely agree /that they migrate to improve their language skills/ N5: Me too N4: for me it was a priority, and the beautiful, huge salary was a benefit

According to N8, many of her fellow migrant nurses already lived abroad before coming to Saudi Arabia and had solid English language skills, thus the improvement of language skills was not that important:

N8: Language probably not, because many of the girls around me were around 30 years old and were somewhere, as a nanny, with their school, picked apples in New Zealand, simply they had a foreign language experience.

N1 repeated his opinion about the financial motivation of migration several times at different moments:

N1: I think they go there for the money, because if they wanted to improve the language, they could go to countries where they make less or similar money as in the Czech Republic, but that´s not the case, they always go to countries where the wages are better.

The participants also questioned the objectivity of the explanation obtained during the quantitative strand "I migrate to learn a foreign language." They believed that it is just a more socially appropriate reason than the economic motivation of migration:

N1: If they admitted that they go to make money, they would feel somehow materialistic? If they migrated to learn a language, why would they return then, because they will not use it here, I believe on the contrary, that they learn the language to go abroad.

According to the participants, the migrating nurse typically does not have a definite plan to master a foreign language abroad and then use this skill for a different but specific task. The simple wish to finally speak a foreign language well and therefore not be restricted in your communication in this global world might be harder to comprehend for English speakers, but it seems to be an initial motive. Only later, the "transformed" nurse explores how to utilize such a new skill professionally. N3 describes how the command of a foreign language had unexpectedly changed her self-confidence:

N3: It was not meant that I will be able to understand a German speaking patient in my /Czech/ unit. However when it actually happened, it was nice. I felt more self-confident, when I was the only nurse out of 20 who could speak with the patient

N5: The fact that the foreign language is practically hard to utilize after a return is perceived very abstractly. They are enriched on a personal level, nurses are glad to be able to communicate when on holiday. They don´t

perceive it like: ´Is it gonna be useful professionally?´ Only after their return they realize, that it would be good to use the language skills.

However, two participants had a definite and concrete plan to learn a language and then migrate again to a different country, where the language skills requirements are higher:

N1: I plan to go to Germany and then later to Switzerland, so I actually want to improve my language skills in Germany

N4: I did not plan to go home from Saudi, I planned to go to Australia, maybe America.

Speaking a foreign language comes in handy some times, and it can help to secure a job where the nurse will be respected more than as a bedside nurse:

N1: It is always a positive thing to speak a foreign language, also here in the Czech Republic." N2: "sure, another chance how to succeed here in the Czech Republic under some, at least a little bit, human conditions.

Moreover, the participants believed that a sufficient command of the local language is important to prevent discrimination abroad (in Saudi Arabia), and that it has an influence on career progression.

N7: /speaking about discrimination/ … somebody could have a university degree, but we look at him – you don't speak the language – you are stupid

N10: It is about the language a lot (everybody agrees).

4.6.12 Theme 3 Circle of leaving and returning, Code: Money as a pull or just an extra bonus?

There was quite a lot of agreement among all of the participants that the financial aspect is a very important reason for the migration of Czech nurses:

N9: Well, those whom I taught in language courses wanted to migrate because of the money, make money and buy a house.

N2: It must have been only financial motivation /to migrate/ because otherwise the people would not give up on bringing new ideas in the Czech Republic.

N10: It´s definitely about money, but somehow not always.

On the other hand for some, the money was less important than the other reasons for migration:

N4: The beautiful, huge salary was a benefit (…) but I met lots of people who migrate for money, maybe it is 50%-50%,

N5: Money was also only a bonus for me.

Even though some Czech nurses migrate primarily for economic reasons, there is a difference between the Czech and Filipino nurses' situation. The Filipino nurses and their extended family typically depend on the foreign income, while the Czech nurses do not need it vitally:

N1: For us it is a luxury, but for them (…) how to say it, it is important to have the job, the Philippines is a poor country, they feed the whole family.

4.6.13 Theme 3 Circle of leaving and returning, Code: Wish to experience something different

A number of the participants in all groups commented on their intent to "learn something new":

N3: I wanted some new experiences and kind of bring them back later

Nx: …it was not easy, but I managed it so nobody had to suffer, so…, of course it was not easy, but I wanted to have this experience, it was all somehow too small here

N8: This generation wants to travel, I feel they just postpone their working career.

Somebody circles the whole world, always running away from something, people are there /in Saudi Arabia/ a year or two, then go to Ethiopia, then to England and they keep looking for something.

Migration as a human right constitutes the fourth attribute of Freeman´s theory. It is an issue which is currently taken for granted by many Czechs, yet was hard to achieve before the year 1989, when the political changes took place in Eastern Europe.

All three previous codes deal with one attribute of Freeman´s Middle Range Theory on nursing migration. It is the motivation and the individual decision to migrate. Motivation for this sample of Czech nurses was mainly the economic aspect of migration, the wish to learn a language and to experience something different. The decision to migrate was made by the nurses alone, the family was not involved in this process.

4.6.14 Theme 3 Circle of leaving and returning, Code: European values as a pull back

Many participants who worked in Saudi Arabia wished for a culturally similar environment after a certain period of time spend abroad; they wished to work again in a "*civilized country".* While there are push factors which drive nurses out of the Czech Republic and some of them are related to the level of respect they receive, the situation in Saudi Arabia is actually similar (lack of respect for a person, in this case because she is female). The only difference is the figure on the paycheck. Three participants agreed that after a certain period of time the migrants in Saudi Arabia started to feel a type of homesickness:

> *N5: I had enough here, I just go home, I miss Europe, and I meant home, it was the most important thing; but also the Christian values…I am fully saturated, I have seen and got it all.*
>
> *N2: I also heard that they cannot stand it anymore /in Saudi/ and I am asking myself: here it not bearable, there it is not bearable, but you get incomparably better money for it there…*

4.6.15 Theme 3 Circle of leaving and returning, Code: Czechs migrate temporarily unless…

All participants offered their opinion related to this topic. Saudi Arabia is a very specific destination country regarding the return back home; its culture, which is fundamentally different from the European culture, facilitates return of the migrating nurses. It seems that nurses tend to return from Saudi Arabia after approximately 2-3 years:

> *N1: If it is a country which is somewhat culturally more similar to us, maybe within Europe, then there is more of a potential that they start to think that after few years they will stay there, or if they find a partner there…"*

These nurses consider their migration as temporary, even though it might actually be a long-term migration. Starting a family abroad or bringing a family along (as indicated by the recruitment agency representative) will seriously decrease the intention to return to the Czech Republic:

> *N1: Unless they get married there and have a family there, they are temporarily there, it could be 1 year or 5 years.*

Some participants suggested that the nurses return home, but tend to migrate repeatedly, and this was also confirmed by the owner of the recruitment agency.

> *N5: If I did not have the goal to have the family and children, I would be already back /in Saudi/, the longer you are gone the harder is the return to home.*
>
> *N3: I have free summers so I returned for the summer /…/ but not for good, I had already made that decision. Yes, for the experience, to refresh it again, because of the language, I admit, and right back home*

Nurses who worked in other countries (the UK, the USA, Switzerland, Italy) seem to be more reluctant to return home:

> *N3: They are there 10 or more years, don´t want to come back home anymore, I was at such point after the two years, I was telling myself: ´I will either return now or I will stay for good´*
>
> *N6: If we did not have to, we would not return, we would stay.*

Five participants from all three groups had migrated repeatedly.

The wish to start their own family was mentioned as one of the reasons to return to the Czech Republic. This was one of the few occasions when any gender related issue came up in this study:

> *N5: I realized family wouldn´t be possible in Saudi Arabia*
>
> *N3: Because to have a kid in Switzerland with a Swiss guy - I rejected this idea (laughs)*

None of the participants mentioned any influence from their extended family. An interesting question, which was not explored in this study, is what will happen after these experienced

migrants have raised children in the Czech Republic. The pool of available informants is currently too small. The immediate family served as a pull back home factor, but it can change in the future.

N2 commented on the possible bias in our knowledge of returning Czech nurses, because it seems that we mostly have information about nurses returning from Saudi, more than about nurses who migrated to other countries.

The dynamics of migration is the fifth attribute of Freeman´s theory and indeed, the participants described rather different patterns of their migration history. None of the migrating nurses described a one-way linear migration, as their plans had changed and surely were not finished.

4.6.16 Theme 3 Circle of leaving and returning, Code: Health care systems abroad work more efficiently

There was a consensus among all of the participants that nurses abroad perform only skilled tasks, unlike in the Czech Republic, although the definition of a skilled task was not stipulated (and therefore become the subject of a discussion). N7, already transformed by her migration, was surprised by the tasks performed by her Czech colleagues. Surely, the nursing workforce abroad is not wasted to perform simple tasks which could be performed by less qualified workers. Similarly, an experienced nurse had advanced competences in the UK:

> *N7: …I visited my old workplace, it was a shock for me, girls were running around with laundry, we had to count and separate dirty laundry*
>
> *N10: I had a night shift and I got a bucket and a rag, that I should have washed the drawers and surfaces in the nursing station*

Further, the Czech system does not recognize, use or show respect for the returnees´ newly gained skills and knowledge:

> *N1: …The question is, whether the returnees are somehow valued here, they have foreign experience, speak languages, know how to work with people*

from all over the world, but if they come back, it doesn´t mean anything in this system

N4: It is not a priority at home that you worked abroad N3: On the contrary, it will be probably punished (everybody laughs)

On the other hand, a facility in Saudi was more open to utilize their skills:

N1: …They told us in Saudi: ´learn our system and if you then think something can be done better, let us know…´

The orientation period for new employees abroad was well organized, transparently documented, and a good command of key skills was ensured. If the workers were familiar with certain procedures, it was respected.

N3: I never experienced that somebody gave me so much attention /during orientation/, they had checklists and followed them, so nothing could be forgotten, /…/ I had 3 months security that somebody will be there with me"

N5: the knowledge of new procedures, every time somebody came to a new unit he had to complete different checklists and based on that, he gained more competences, /../ in Saudi we had preceptors for 6 weeks, he was always with me, over and over, knew what I know and I don't.

N6: they have their competency book, with the procedures they can do and they cannot do /…/ if the person had worked somewhere before, they watch him doing it once or twice and he could administer IV meds

N10 expressed disappointment that advanced skills of nurses in the Czech Republic are not quite official, and an active approach to work is not recognized; N4 remarked that workers in general are not cared for in the Czech Republic. One participant mentioned that it is normal abroad that the nurses take charge and act professionally, and this participant learned abroad to do this too:

R8: If we had a medication error, then when we have our meetings we talked about how to improve, I said: ´really easy, everybody should do their own job…´

This professional growth could be viewed as one of the first consequences of migration in Freeman´s Middle Range Theory, when the migration has certain consequences on the individual - in this case, positive.

Another issue was the perceived chaos in the Czech health care system, as well as the uncertainty and confusion of the leaders in Czech nursing which was blocking any substantial progression in Czech nursing on many levels - starting with a national vision, down to the functioning of one hospital unit:

> *N6: It feels like the people in the Ministry and maybe lower, kind of don´t know what to do and instill this confusion in the nurses, the nurses don't know what will happen, I think it deters people from studying nursing and also to do anything a little bit extra in the profession.*
>
> *N5: In a Czech workplace, everybody does it the way he wants, and there is not a clear procedure.*
>
> *N6: on the other hand there /the UK/ I had the feeling that I am valued, my work is rewarded, they treat me well and I just like the work, but here I still like the work, but I know that nobody will praise me, nobody will support me to learn more, nobody forces me to do anything*

These factors clearly contributed to pushing some of the participants away from the home country, and they found a more respecting environment abroad.

The participants in group 3 discussed factors which motivate Czech nurses to return to Czech nursing. The only two reasons identified included that the nurse really likes her job:

> *N8: you like it, I like it, to hold their hands when they are sick N9: Yes you like it N7: I see this as the only reason (everybody laughs) I am sorry, but I feel it this way*.

The second reason was that the nurse does not have any other career possibilities:

> *N10: they don't really have any other choice, either you say: "it is not worth it, I don't want to be a part of this" or you make the step backward and you fall into it, there is no other choice.*

The fact that the source country is not able to utilize the skills of the returning migrants and they continue to migrate or work in different fields means that the migration had negative consequences on the source country. In this case, causing brain drain and increasing the shortage of nurses.

4.6.17 Theme 3 Circle of leaving and returning, Code: Czech health care has little interest in innovations

This category could be included in the previous one, but I prefer to keep it separate to point out the reluctance to change within Czech nursing. The participants in the qualitative strand agreed that the reactions of their colleagues were often negative when they found out that he/she had worked abroad. Similarly, about four respondents in the quantitative strand reported not telling anybody about their past migration in order to prevent any negative attitudes of their colleagues:

> *N10: I had not told anybody yet, but of course it got there somehow and the view of my colleagues was distorted and their attitude was hostile, or I perceived it so. Time will probably help, but then you wonder if it is worth it*

If the returnee nurse insisted on introducing changes which she brought from abroad, it was often rejected by her colleagues:

> *N1: She was told: ´We do it this way, don´t bother us with new things´*

Similarly, the managers in the Czech Republic did not appreciate the participants´ foreign experience:

> *N5: I did not experience any problems, but it did not have the benefit that everybody would say: ´Wow, great, we hire you immediately!´*
>
> *N10: I don't know maybe they /the managers/ feel threatened*

Return migration has multiple obstacles - the returnees have to have a strong motivation for return and possess various strategies to cope with it:

> *N10: Then you fear to return, my friends were afraid, they knew the health care at home is different, whether you can integrate again /to the Czech system/ really, financially they will be evaluated differently, then the connections are broken…*

N2 was surprised that the returnees, although transformed by migration, are sometimes able to keep working in the Czech system without making use of their current and advanced nursing skills:

> *N2: They learned a certain discipline, they learned how to survive abroad and they function the same way here. If I didn´t know it, I wouldn´t notice /that they worked abroad/.*

According to Freeman´s theory, this fact has negative consequences on the provision of health care in the source country, because these systems are less able to improve and modernize.

4.7 Summary of Chapter 4

In this study, the quantitative data were managed using descriptive statistics, and qualitative data were reduced into codes and themes. The available data from all three strands of this study are compared in the following Table 19; they are also compared with the relevant literature. Even though the quantitative data was originally expected to take priority, the priority slowly shifted toward a qualitative approach (Onwuegbuzie and Leech, 2006), mainly due to the limits in sampling and sample size. However, the qualitative approach allowed for a collection of rich data on Czech migrating nurses.

Some results and findings from this study on Czech migrating nurses differ from previously conducted studies. A deskilling of the migrating nurses is often described in the literature (Tjadens et al., 2013), but my sample of Czech nurses migrating mainly to Saudi Arabia did not report deskilling very often. Migrants who work abroad below their qualification level usually lose their previous professional skills and knowledge, but the very opposite was reported by my respondents and participants. Similarly, the typically very demanding credentialing procedure in the destination country (Newton et al., 2012), was not considered to be overly difficult by my respondents.

While nurses are reported to return from some destination countries more than physicians for example (Kingma, 2006), the most common destination country in this study (the Kingdom of Saudi Arabia) probably facilitated return migration. Moreover, the Czech population reported preferring temporary migration (Vavreckova et al., 2006). Even though a repeated, circular migration is nowadays common (Schultz and Rijks, 2014), the majority of the Czech nurses did not migrate repeatedly. The returning Czech nurses seemed to start working in Czech hospitals, it is unclear from our results whether and how many will stay in their clinical positions permanently.

Being encouraged to migrate by the family and sending remittances to the extended family remaining in the home country is a very common strategy for migrants from the Philippines, Africa and Asia (Humphries et al., 2009a), but is does not appear to be a tactic employed by my respondents. Instead, a personal financial improvement, in combination with other benefits (an improvement of language skills and having new adventures), seem to be the motivators of Czech nurses in this study. This expectation of multiple benefits has been described in other studies (Dywili et al., 2013).

Some results of previous studies are rather similar to my results and findings. The communication barrier in the destination country (Palese et al., 2007) has been consistently reported, and it was an issue for my respondents and participants as well. Two other such aspects were the differences in nursing practice between the host and home countries (Blythe et al., 2009) and the limited ability to transfer new skills and knowledge back to the source country's nursing system after return (Tjadens et al., 2013).

Information from literature	**1st qualitative strand findings**	**2ndquantitative strand results**	**3rd qualitative strand findings**
Migrating registered nurses often work abroad below their qualification (Tjadens et al., 2013)	Register – Not assessed Recruiting agency only sends abroad nurse as RNs	70% of the respondents eventually work abroad as RNs Saudi Arabia – only as RNs UK – more worked as non-RNs	Not assessed - All of the participants worked as RN, it was an inclusion criterion in the 3rd strand.
Nursing skills and knowledge - often reported deterioration (Haour-Knipe and Davies, 2008)	Register – not assessed Recruiting agency was positive about the increase in nursing skills of the returning nurses, It causes problems with reintegration	79% of the respondents reported an improvement of their skills and knowledge 83% very and moderately positive experience of migration	Unanimous improvement of professionals skills and attitudes, transformation is so fundamental that they cannot reintegrate
Return migration common (Kingma, 2006)	Register- Not assessed Recruiting agency – temporary return to CR	46% of the respondents returned, 16% returned but are not sure if permanently, 10% no plans to return 25% migrating for 2-3 years	9 nurses out of 10 returned, but convenience sample of available nurses
Circular migration is common (Szpakowski et al., 2016), (Schultz and Rijks, 2014)	Register – Not assessed Recruiting agency – circular migration 2-3x, then family	77% did not report circular migration (28% does not want to migrate again)	About half migrated repeatedly
Nurses send remittances to home country (Humphries et al., 2009a) Buy real estate upon return (Massey, 1998)	Not assessed	Majority (58%) does not send remittances, 43% bought real estate after return	Not assessed
Economic improvement is the main motivator for migration (Dywili et al., 2013)	Register - Economic reasons, adventure Recruiting agency – not assessed	Language skills improvement is the main motivator New experience - second place	Fundamental improvement in language skills, economic gain is important but not vital

		Financial motivation - third place	
Working as RN after return - not assessed	Register – Not assessed Recruiting agency – they start working as RN, but only temporarily	50% of the respondents work in the CR as RN after return 14% maternity leave 10% out of health care 8% teachers and managers	3 participants out of 10 work as part time RNs, but one is planning another migration 1 works as a teacher 2 maternity leave 2 out of health care
Problems with credentialing (Cuban, 2010), (Newton et al., 2012)	Register – easier within EU, automatic recognition common now, easy to SA Recruiting agency administers credentialing procedure	40% no problems with credentialing 20% credentialing took long time	Not assessed
Nursing practice is different abroad (Blythe et al., 2009)	Register- not assessed Recruiting agency – yes more developed, we should use this potential	Yes, different nursing practice causes difficulties after arrival	Agreement that nursing practice abroad is different + more developed
Communication in foreign language – main barrier (Palese et al., 2007)	Register – not assessed Recruiting agency – language skills main obstacle for more migration	The most difficult issue connected with migration 57% reported that their language ability was sufficient for common situations, but not for solving sensitive or difficult issues 18% rather insufficient	Agreement that the language barrier was a big problem initially, influencing integration
Inability to use new skills after return (Tjadens et al., 2013)	Register – not assessed Recruiting agency confirms it	28% cannot use their new skills, 37% only some 38% of returnees well accepted by colleagues	Problems with implementation of the new skills Not very well accepted
Various studies	Recruiting agency – younger, post-secondary	Female, younger, single, educated in similar	Female, slightly older, mainly post-secondary

	education or specialization Register - younger	percentage at high school level, specialization, post-secondary level	education,
Cascade pattern of migration (Dumont and Zurn, 2007)	Recruiting agency - Gulf region countries Register – Gulf region countries, UK, Austria and Germany, other.	Destination - Saudi Arabia RNs, German speaking countries, English speaking countries	Destination - different countries, Saudi Arabia 6x
Parents encouraging migration (Alonso-Garbayo and Maben, 2009)	Not assessed	70% of parents did not encourage	Not assessed
Discrimination of internationally educated nurses (Jose, 2008), (Newton et al., 2012), (Moyce et al., 2015)	Not assessed	61% never or only few times experienced workplace discrimination, 71% never experienced workplace abuse Less often in UK	About half reported experiencing discrimination after arrival, connected with language ability

Table 19. Comparison of the collected data with literature

5 Chapter – Discussion

5.1 Purpose of the study

The main purpose of this study was to explore the important aspects of the migration of Czech nurses, because this topic has been under-researched, and many issues, such as their personal experiences, their outflow, and their return numbers, have not been previously explored or published. The objective of this study was to contribute to filling the substantial gap in our knowledge of most aspects of the migration of Czech nurses.

5.2 Research questions

This study aimed to answer the following research questions:

1. What has been the out migration pattern of Czech nurses responsible for general care?

1.1. How do the push and pull theory and the theory suggested by Freeman et al. explain the migration of Czech nurses?

2. What are the motives of Czech registered nurses for migration?

2.1. What are the motives of Czech nurses for return migration and what is the impact of migration on their lives?

3. Can the experience of Czech nurses who migrate be described?

3.1. What is the impact of the Czech nurses´ migration on the Czech health care system?

4. Can an assessment of the number of Czech nurses who migrate but are not employed in the destination country as nurses responsible for general care be made?

What follows is a brief summary of the findings from the literature I reviewed for this study, and then I describe the most interesting findings and results of this study on the migration of Czech nurses. Next, l interpret these results in detail, and then place them in a wider socio-cultural context. In the conclusion, I have highlighted points related to the migration of Czech nurses which are relevant for the current state of Czech and global nursing, and I have explained my reasoning for doing so. Defining the limitations of this study, the study´s implication for nursing and suggestions for future research close this final chapter.

5.3 Main findings from the literature review

The following section summarizes the main and relevant facts from the published literature and grey literature which I reviewed.

Globally, the migration of people to developed countries has been on the increase (Sabbati et al., 2015), (UNFPA, 2016). Migrants are typically moving from low income countries to higher income ones, and an increased migration rate very often points to serious problems in a country (Hanson, 2010). In spite of the mobility-facilitating policies in the EU, the general intra-European migration is rather small compared with the migratory flows of non-EU citizens, while the monitoring of all of these flows is not very exact (European Commission, 2010). There is only a limited amount of evidence describing the international migratory patterns of Czech citizens, and it seems that the Czechs have a lower migration rate in general (Vavreckova et al., 2007).

The migration of nurses around the globe has been a common phenomenon for a couple of decades, and it is currently reinforced by the global shortage of nurses (OECD, 2010b). Migration has positive, as well as negative, consequences on the source countries, on the destination countries and on the migrant (Kingma, 2006), (Glinos, 2015). Certain parts of the world, including the countries of the EU (European Parliament, 2005) have regulations in place attempting to manage the migration of health care professionals. While exact and detailed monitoring of the migratory flows of health care workers around the globe remains in general insufficient (Dussault et al., 2009), the experiences of the migrating nurses and the

consequences for the source and the host countries have been mapped more effectively in the last few years. Many of these studies have been conducted on the typical nursing migrants from the Philippines, India and Africa (Wismar et al., 2011b), (Schultz and Rijks, 2014).

The literature review highlighted that the reasons for migration are often primarily economic, or related to unsatisfactory working conditions in the home country. These primary reasons are frequently coupled with some other reasons, such as professional development or the wish for an adventure. The high demand for nurses in western countries is another pull factor, together with the activities of recruiting agencies (Buchan et al., 2006c), (Schultz and Rijks, 2014). During their journey, migrating nurses face serious obstacles, such as credentialing difficulties, the language/communication barriers in the host country, a fundamentally different culture and nursing practice and sometimes discrimination (Jose, 2008), (Cuban, 2010), (Moyce et al., 2015). Some authors have suggested introducing measures aimed at the more efficient integration of internationally educated nurses into the destination country workforce (Sherman and Eggenberger, 2008).

Some nurses work abroad in less qualified positions, which is considered to be "brain-wasting" (Haour-Knipe and Davies, 2008). Nurses get transformed by their migration, and among other things, their professional knowledge and skills change (Magnusdottir, 2005), (Bludau, 2012). Less is known about the reintegration of returning nurses back into the source country's nursing system, or about how to practically manage the migratory flow without imposing on human rights.

The review revealed that only a few studies on the migratory trends of the Czech population exist (Vavreckova et al., 2007). Similarly, there has been a minimal amount of published work related to the migration of Czech nurses. The Czech Ministry of Health quantifies the intention of Czech nurses to migrate and work abroad (Hellerová, 2009) in a regulated health care profession[42], based on the number of requests to have their qualification recognized. Subsequently, the current migratory flows are estimated based on these data. However,

[42] EU regulated health care professions include: general care nurse, midwife, doctor, dental practitioner, pharmacist (European Parliament, 2005)

these numbers are only rarely made public. Compared to nurses from other post-communist countries, it seems that Czech nurses migrate in smaller numbers and they prefer temporary migration. The review highlighted that the available but limited data suggests that Czech nurses migrate mainly to neighboring Germany and Austria, to Great Britain (in line with the "cascade" suggested by OECD (OECD, 2014)) and lately to certain Arabic countries. The review also identified some recently defended research theses from different Czech and US tertiary educational institutions which somehow deal with the migration of Czech nurses. These theses tend to explore a partial aspect of the migration of Czech nurses, very often their motives for migration and their experiences (Bratinková, 2011), (Bludau, 2012).

A nurse specific theory on migration was suggested in 2012, and it seems to explain nursing migration in a more comprehensive way than the previously used models. This theory expands the push and pull theory, mainly by acknowledging and categorizing the consequences of migration for different stakeholders in the process of migration (Freeman et al., 2012a). Freeman and her colleagues called for a testing of their theory, which I attempted to do when I used this theory (in the interpretation section) as a framework to be filled in with the specifics of Czech nurses´ migration.

5.4 Summary of the results and findings from this study

This section sets out the main results and key findings of this study. I begin by describing the results and findings from my study, which offered answers to my research questions. I then interpret these results and findings in context, based on the available evidence from the literature, as well as by using my knowledge of this phenomenon. In the interpretation section, I present a model case of a fictional Czech migrating nurse, and then I describe the antecedents, attributes and consequences of the nurse specific theory on migration relevant for the Czech situation. The interpretation is followed by the conclusion of this thesis.

The mixed method study presented here consisted of three strands. The strands are listed below, while the results and findings presented in this summary are already mixed[43].

1. The first qualitative strand consisted of two interviews: one with a representative of the Czech Register of health care workers and one with a representative of a Czech recruiting agency. The goal of these interviews was to establish and confirm basic information about the migration of Czech nurses, because I was unable to locate any published sources of this information.
2. The second, quantitative, strand used a web-based self-administered questionnaire to explore the trends, motives and experiences of Czech registered nurses who worked abroad at some point in their career.
3. The third qualitative strand used the focus group technique to research the results of the previous strand in more depth, and to validate the information from the previous strands.

Three quarters of all Czech migrating nurses participating in the second quantitative strand of this study eventually worked abroad as registered nurses[44], they were younger than 30 at the time of their first migration, single and predominantly female. The most common destination country was Saudi Arabia, followed by Germany and the UK.

Almost all of the respondents from the quantitative strand felt that their professional skills improved because of the migration, and they evaluated their foreign experience positively. More than half of the migrating nurses eventually returned back to the Czech Republic "because of their family", but some of them were not sure whether it was a permanent move. About half of the returnees worked in the Czech Republic as registered nurses providing direct care, and mostly they reported not being able to utilize all of the new knowledge and skills which they had gained while practicing nursing abroad; only a few respondents worked as nursing teachers or managers after their return.

[43] All of the results and findings from each strand are fully described in Chapter 4.

[44] It differs from other published studies: (Buchan at al., 2006c), (Cuban, 2010), (Palese at al., 2010)

The international migration of Czech nurses who plan to work abroad in other professions than as registered nurses is very hard to assess[45], as indicated in the literature (Buchan and Aiken, 2008a). The UK was the most popular destination countries for these nurses in the presented study; the nurses tended to return home more often than the nurses working abroad as registered nurses. About one third of these respondents had their Czech nursing qualification eventually recognized in the host country, another third was not successful and the rest did not apply for recognition for various reasons.

Considering the fact that the main destination country was Saudi Arabia, it is not surprising that the respondents often reported using services of a recruiting agency to find employment abroad[46]. The families of the Czech migrating nurses were typically not involved in the decision to migrate and the migrants only rarely sent remittances home. Instead, they often bought real estate in the Czech Republic with their foreign savings.

The participants in the third qualitative strand of this study extensively discussed the most common reason for migration selected by the respondents in the second quantitative strand of this study: the "wish to improve my language abilities." The focus group participants concluded that in order to migrate, the nurse has to be able to communicate on a certain level in the local language, otherwise she/he would not be granted a position of an RN in the destination country. For some of these participants, reaching fluency in a foreign language was also a major pull factor, even though at the time they did not have a concrete plan for how to consequently use the improved language skills.

However, some of the participants described their insufficient language skills upon arrival to the destination country which were picked up by their co-workers and which made their adaptation more difficult. This demonstrates the importance of a sufficient command of the local language, as well as the fact that there are loopholes in the selection process conducted by the employers.

[45] The sample of respondents in this study, who worked abroad in less qualified positions was rather small (N=37)

[46] As confirmed by the representative of the recruiting agency, migration to Saudi Arabia is possible only through cooperating with a recognized recruitment agency.

The wish to experience "something new" ranked as the second most relevant motivation to migrate for the Czech nurses, but then, especially for the Czech nurses in Saudi Arabia, they felt that they wanted to return to a more familiar culture after some time, usually after 2-3 years. This length of the typical time period spent abroad matched the estimate of this period given by the recruiting agency representative. Even though the majority of the respondents in the quantitative strand did not migrate repeatedly, the participants in the focus groups and the recruiting agency representative mentioned that the fact that the health care systems abroad seem to function more efficiently than the Czech health care system was a factor for a repeated migration. In the third strand, the participants identified only two reasons for returning to Czech nursing: love for the nursing profession and a lack of other opportunities.

The participants in the qualitative strand believed that by prioritizing the wish to improve their language skills and to experience something new over the economic reasoning, the respondents in the second quantitative strand could have been justifying their migration with a more socially acceptable motivation, rather than admitting the common economic motivation for their migration, which ranked in third place[47]. The participants also suggested that for the Czech nurses, migration is not a step intended to provide income for the whole family back home, as is the case in some other countries.

Unlike typical migrants from the Philippines (Jose, 2008), (Newton et al., 2012), many of the Czech respondents did not report any serious difficulties with finding work abroad, but consistent with the literature (Magnusdottir, 2005), (Tregunno et al., 2009), (Newton et al., 2012), the professional communication in a foreign language and the different nursing practice were rated as the most difficult issues after starting to work in the host country. Interestingly, the differences between the host country's and the Czech nursing practice seemed to be greater in the English speaking and Arabic countries, compared to the geographically and historically closer German speaking countries.

[47] The values assigned by the respondents to the first three reasons for migration were very close to each other, which means that these reasons were of similar importance to my respondents.

The known financial discrimination of nurses based on their nationality in Saudi Arabia (Mitchell, 2009), (Bludau, 2012) was also described by the nurses participating in this study, and it naturally caused some interpersonal problems at the workplace. However, only a few of the Czech nurses in this study working in Saudi Arabia reported that they personally felt discriminated against by their colleagues; the nurses working in other destination countries reported discrimination even more rarely, but this topic is very sensitive, therefore the results must be interpreted with caution. The discrimination was related to the (lack of) fluency in the local language. Also, the career opportunities abroad were viewed as unlimited, as long as the nurse stayed abroad long enough and commanded the local language at an almost native speaker level.

The participants in the third qualitative strand described in detail various aspects of nursing professionalism which they perceived as being more developed abroad and less developed in the Czech Republic (e.g. the effective use of nursing standards). They also reflected on the lower recognition or lack of respect for nurses in the CR by their colleagues, and the lower degree of autonomy of Czech nurses. Findings from all three strands suggested that the migrating Czech nurses were transformed by the migration and it actually complicated their return to Czech health care. The participants thought that the workplace relationships abroad are better than in the Czech Republic. About a third of the participants in the second quantitative strand did not intend to migrate again in the future.

5.5 Interpretation of the results and findings

In this section I will concentrate on interpreting any results and findings which bring new information about nursing migration. In order to answer the postulated research questions in depth, I begin by illustrating the Nursing-specific middle range theory on migration (Freeman et al., 2012a) by applying it to a "fictional" Czech migrating nurse. The characteristics of this nurse were based on the results and findings of the conducted study. Later, I explore the above-mentioned theory in detail, and then I conclude this chapter.

5.5.1 Czech model case

Šárka is a 26-year-old Czech registered nurse, she is a graduate of a Bachelor's nursing program, and she is single. She had first worked in a local hospital in her hometown for a year. Then she moved to Prague and she has been working for two years in the surgical post-operative unit of a large teaching hospital. She lives in a nursing dormitory. By now she is experienced in working with the typical patients in her unit, likes her work, but knows that any promotion is years away and she starts to look for new challenges. Her monthly salary of about 900 Euros is sufficient to live on in the dormitory, and for having hobbies and fun with her friends, but it is not enough to buy or rent an apartment on her own.

Her previous colleagues told her about working in Saudi Arabia and she checked the web sites of the two Czech recruiting agencies. She had English for 10 years in school, followed by a course in medical English in the nursing program. She can hold a simple conversation in English, but she has never used English on a daily basis. She starts to cooperate with a recruiting agency, attends courses in professional nursing English and studies general English with a private teacher as well. In about eight months she is ready to have a telephone interview with a potential employer in Saudi Arabia, and she is immediately offered a contract. Her parents are not involved in this decision, she is very anxious whether her language and professional skills will be sufficient, but she accepts the two-year contract for working in a surgical ICU in Saudi Arabia for 3 500 Euros a month.

After her arrival in Saudi Arabia, she is amazed by the well-organized orientation period, overwhelmed by the different culture and the multinational health care team, and she is feeling very insecure regarding her nursing skills. She struggles with communication in English, especially in English medical terminology. However, within one year she is well adapted to her environment and she mentors new nurses. Her salary allows her to travel around the world, buy anything she wants and even save some money. She makes a lot of friends from all around the world, and she extends her contract by an additional year. After three years in Saudi Arabia she is transformed into a very confident global nurse with specialist skills and advanced competencies in the latest procedures in cardiosurgery, and she is fluent in English. However, she feels that she cannot live in the different culture

anymore, and she returns home. She buys a flat in Prague with the saved money and starts working in the most prestigious cardiosurgery department at a teaching hospital in Prague.

The Czech system is not able to recognize her advanced skills, and she is given a job for newly hired nurses; she is shocked, and within six months she is back in Saudi Arabia, where her skills are respected. She returns home two years later and starts to work as a coordinator of clinical studies, using English on a daily basis. One year later she is ready to have a family. It is not known what will happen after her children get older.

5.5.2 Nursing-specific middle range theory on migration applied to the Czech situation

I used Freeman´s Nursing-specific middle range theory on migration as a lens to describe the characteristics of Czech nursing migration in detail. According to Freeman, some antecedents of migration (the push and pull factors) have to be present for the migration to take place. The attributes of Czech nurses' migration (or characteristics/issues related to migration) are described below, and then I discuss the consequences of migration for the different subjects in the migration process. (Freeman et al., 2012a).

Antecedents of migration

a) Economic motivation for migration

Many studies have concluded that the most common pull factor for the migration of nurses is the economic reason (Troy et al., 2007), (Jose, 2008), (Humphries et al., 2009a), (Dywili et al., 2013). A typical push factor for nurses from less wealthy countries is their low salary in their home country (Palese et al., 2007), (Palese et al., 2010), (Bratinková, 2011), (Szpakowski et al., 2016).

Although the motives for migration were rather closely grouped, the majority of Czech nurses in the quantitative strand of this study ranked the economic motivation of their migration in third position. The first two motivators were the wish to improve their foreign language skills and the wish to gain new experiences. The participants in the focus groups questioned the validity of this self-reported result, believing that some respondents were cautious in answering this sensitive item. These participants clarified that the economic motivation is sometimes the most important deciding factor, but they paired the "obvious"

expectation of a high salary in the destination country with another motivation, typically with improving language proficiency or gaining new experiences. This “pairing” has been described in previous studies as well (Bludau, 2012), (Dywili et al., 2013) and it could entail either a (semiconscious) attempt to justify the “materialistic” motivation for migration with more acceptable reasons. Alternatively, this perceived double benefit could function as a reduction of the high “costs” of migration.

Considering that nursing is a mentally and physically very demanding profession in the majority of countries around the globe, as well as the fact that unsatisfactory working conditions are changing very slowly, it is likely that migrating nurses are looking for the relatively highest remuneration (with the USA being at the top of the cascade (Dumont and Zurn, 2007)), which would offset the demands of the job, which are similarly intense in every country. One participant in the focus group described this issue thus: “*the job is unbearable in the CR and in Saudi Arabia, but in Saudi you at least get much more money for it*.”

Given the considerable reliance of Western society on health care and care services, it is advisable for our society to promote nursing as a more attractive profession. Apart from other measures (the role of the media, ensuring appropriate working conditions, quality education, etc.), a direct way to increase the attractiveness of a profession is to pay the members of this profession competitive salaries (Buchan et al., 2014a)(p. 162). The decision-makers in each country need to agree on what a decent salary is and balance it with the available resources. If decided wisely, it will prevent large numbers of nurses from migrating out of the profession and out of the country, just as the Polish migration slowed down after a salary increase was implemented (Wismar at al., 2011b). For example, German nurses, while dissatisfied with their lack of professional autonomy, put the dissatisfaction with their remuneration in second to last place (Zander et al., 2013). According to the most recent information on gross monthly income of a professional nurse in 2005, Germany came in at 2500 Euros. The same figure for a Czech nurse was 670 Euros (Worldsalaries.org, 2008).

While supporting the extended family left in the source country was not a motivator for the Czech migrating nurses in this study or the study by Bludau (Bludau, 2012), many participants reported buying a real estate with the saved finances. A typical Czech nursing

salary would not be sufficient for such a purchase, though it is an obvious need at a certain time in their lives.

b) Personal motivation for migration

Since international travelling was restricted during the communist times, speaking English or German was not considered a necessary skill, not for nurses, nor for the general public. Czech nurses who happened to be proficient in a foreign language after the year 1989 suddenly possessed valuable capital. This social capital offered them more employment opportunities in better paid and less demanding professions. The language skills of the current young generation of Czech nurses are slowly improving (see Šárka´s case study). However, the actual ability to communicate in English or German is still often less than optimal for being offered a nursing position abroad, which limits a more intense migration of Czech nurses (Bludau, 2012).

For some Czech participants in this study, the wish to reach fluency in a foreign language was the most important reason for migration. This wish to fluently command a foreign language could imply that citizens of a formerly politically secluded country finally want to fully participate in the world, something which was not previously possible (also suggested in the literature as "recognition, new sense of self and belonging to the global arena" (Bludau, 2012)). Nevertheless, the participants in this study often did not have any concrete plan on how they would professionally use the newly gained proficiency in the foreign language. Only after their return, when they actually possessed the new language skills, did the Czech nurses start to explore how to utilize these skills.

This is very plausibly explained by Ghodsee (Ghodsee, 2005) - that the Czech nurses, just like the female Bulgarian tourism workers after the political changes, are "relocating their portfolios of skills and adjusting their trajectories toward gaining privileges in a new system." One participant in my focus group put it more plainly, stating that the ability to speak a foreign language offers *"…another chance how to succeed in the Czech Republic under some, at least a little bit, human conditions."*

The dissatisfaction with the working conditions in the home country (Kaufnerová, 2012), (Palková, 2012), and the resulting search for more pleasant and respectful conditions could be another personal motive for migration. While the nurses abroad work hard as well, their work was viewed as more respected, meaningful, and thus more rewarding. Similarly, the participants in the third qualitative strand of my study and also Palková in her study reported that the interpersonal relationships in the workplace abroad were better and more professional.

The Czech working conditions might be slightly better than the conditions in the other post-communist countries (Gurkova et al., 2013), but they are less favorable than those in Western countries, and they are probably gradually declining with the current worsening of the nursing shortage (ČTK, 2016). The fact that the conditions in the Czech health care system were more satisfactory than in other countries could partially explain the fact that Czech nurses, until now, have tended to migrate in smaller numbers than their colleagues from other Central and Eastern European countries. Bludau´s argument that the Czech apprehension towards migration originates from the communist times, when the opportunities for migration were extremely restricted to a few Soviet allied countries (Bludau, 2010) does not explain why Polish and Slovak nurses (with a very similar history) have much higher rates of intention to leave their country (Gurkova et al., 2013). The lower affinity of the general Czech population towards migration (Vavreckova et al., 2006), and the smaller necessity for such a move is probably the cause of this phenomenon. While the Czech population (and Czech nurses) probably do maintain a certain awe of living and working in a foreign country, this unexplored territory manages to actually lure the younger generation away (Vavreckova et al., 2006). This group of nurses closely matches the category of "backpacker" migrants recently described by Buchan (Buchan et al., 2014a). The nursing profession, combined with the global shortage of nurses in many unexplored and therefore "exotic" countries, provide young Czech nurses with an unexpected and uncommon opportunity. Šárka is an example of a backpacker migrant.

As a result, Czech migrating nurses enjoy the fact that they can explore new horizons and learn new things (Moyce et al., 2015) while exercising their profession and being paid well for it. The nurses in the qualitative strand viewed their salary as "*huge and beautiful,*"

hinting at their extraordinary satisfaction with this expression of respect and appreciation of their work. Since the ability to travel is limited by an average Czech nursing salary, the migrating nurses regarded travelling as an extra benefit (Bratinková, 2011). Similarly, the ability to freely travel was not possible before the political changes in 1989. Participants in my focus groups reported that certain cohorts of Czech nurses want to make up for this previous inability, and the wish for travel is known from literature (e.g. Kingma described this in her categories of nurse migrant as an adventure migrant and a holiday migrant (Kingma, 2006).

c) Historical factors influencing migration

The Czech Republic is lacking a colonial history (Tjadens et al., 2013). Apart from the connection to the Soviet Union in the second half of the 20th Century (which is nonetheless irrelevant for nursing migration), the only historical tie is to the neighboring German speaking countries that were once part of the Austro-Hungarian monarchy. These countries seem to share a somewhat similar approach to educating nurses and to nursing practice. Indeed, the respondents in the quantitative strand reported that adapting to the local nursing practice was easier for the nurses migrating to German speaking countries, as compared to migrants to English speaking and Arabic countries. At the same time, Czech registered nurses worked more often in less qualified positions (as health care assistants or as caregivers) in the UK. This “deskilling” was reported less often by nurses migrating to German speaking countries and not reported at all by nurses migrating to Saudi Arabia, where Czech nurses assume only RN positions as confirmed by the representative of the recruiting agency. The possible explanation of the “deskilling” in English speaking destination countries is the different nursing practice and the more demanding credentialing procedure in the UK, with higher requirements placed on the nursing qualification education.

The other issue is the availability of a convenient destination country. The CR has been a common destination country for Slovak nurses, and this migration route is considered “easy” because of similarities such as language, nursing education, nursing practice, and history, and more nurses are willing to pursue it. Czech nurses on the other hand do not have a similarly “easy” and convenient destination country available, and therefore might be less

willing to migrate, despite the fact that the EU laws make internal mobility administratively relatively easy, compared to the migration of nurses from the rest of the world.

Conversely, even though there are not any historical ties to Saudi Arabia, the local demand for nurses and mainly the activities of the recruiting agencies acted as a strong pull factor for Czech nurses (Freeman et al., 2012a), and Saudi Arabia was the most common destination country for Czech nurses in this study, where the recognition process is simple and carried out by the recruiting agencies. The Arabic destination countries need to be added to the migration cascade type pattern (Dumont and Zurn, 2007).

d) Educational and legal factors influencing migration

These factors pull nurses to countries where some interesting type of education is being offered: formal specialization, an academic career, advanced competencies or simply informal but interesting practical experience. These factors were mentioned by the respondents and the participants in the focus groups. Indeed, the majority of the respondents and participants reported an improvement of their professional skills and knowledge after migration.

Another pull factor from this realm is the possibility of automatic recognition of the nursing qualification within the EU (European Parliament, 2005). This factor can be also included in the "legal factors" or antecedents for stimulating migration. As reported by the representative of the Czech Register of Health Care Workers, the EU-wide regulation of qualification recognition certainly simplifies the credentialing process for Czech nurses, even though the recognition can still be viewed as time consuming and administratively demanding, especially in some destination countries.

However, the respondents in this study did not encounter any fundamental problems when they were obtaining a work position abroad. The report of the relatively simple credentialing process could have been influenced by the main destination country (Saudi Arabia), for it requires only a national nursing registration and the document verifying a professional qualification. On the other hand, the credentialing process is typically one of the lengthiest obstacles which nurses around the globe face (Jose, 2008), (Newton et al., 2012). The Czech

nurses in Bludau´s study reported problems with the recognition of their qualification by some of the EU states (Bludau, 2012). This could have been caused by the fact that the interviews were conducted in 2008-2009, thus reflecting experiences early after the Czech Republic joined the EU, when the majority of the nurses had graduated from a Soviet model four year high school which combined general and professional nursing education at a secondary level.

e) Political factors influencing migration

The political situation in the Czech Republic (Kaufnerová, 2012) was rarely mentioned by our respondents and participants as a motive forcing Czech nurses to migrate. Bludau drew similar conclusions regarding the impact of politics on Czech nursing migration, which differs from results in certain African countries (Haour-Knipe and Davies, 2008).

Based on the results from my study, I believe that the most relevant push and pull factors motivating Czech nurses to migrate are the economic and personal reasons, offering the Czech nurses better financial rewards combined with other interesting benefits.

The attributes of migration

Freeman et al. (2012) stipulated five attributes of migration, all of which influence the migration of nurses. The first one describes whether the motivation and decision towards migration is made entirely by the migrating individual. The results of this study show that in the Czech Republic, unlike in some typical source countries such as India or the Philippines (Troy et al., 2007), (Humphries et al., 2009a), (Alonso-Garbayo and Maben, 2009), the decision to migrate is considered and made by the individual nurse. In the Czech individualistic society, the wider family is not typically involved in this decision and does not later rely on any remittances sent by the migrant.

The second attribute relates to the external barriers and facilitators of migration. In accordance with literature (Kingma, 2006), (Bludau, 2012) and based on the information of the recruiting agency representative, the major factor preventing Czech nurses from more extensive migration is their limited language abilities. As shared by the representative of the

Czech Register, inadequate professional education is currently a less common barrier, because of the current EU Directive on the recognition of professional education with which the Czech nursing education is at present harmonized. This regulation is actually facilitating the mobility of Czech nurses. The facilitating influence of the recruiting agencies was described above. Similarly, the shortage of nurses in the developed countries facilitates the migration of Czech nurses.

The third attribute describes the freedom of choice, or lack thereof, to migrate, and whether migration is forced by external factors which the nurse cannot affect (e.g. the lack of full-time work in the home country.) It seems that also from this perspective, the migration of Czech nurses is completely voluntary. However, if the currently deteriorating working conditions of nurses (ČTK, 2016) continue to worsen in the Czech Republic, migration could become a necessity in the future, because the nurses will not be able to perform their work under deteriorating working conditions. In such case, the nurses will more often be forced to migrate because of the unacceptable local conditions, rather than choosing to migrate for personal reasons such as learning new things.

The fourth attribute of nursing migration is the human right to migrate, which is not as obvious as it may seem. Only 27 years ago, before the political changes in 1989 in Czechoslovakia, this basic human right was practically not observed. This historical fact might be influencing the Czech nurses as well - but whether it influences Czech nurses to migrate, or not to migrate for that matter, was not explored in this study.

The fifth attribute describes the dynamics of migration. The dynamics of migration have changed in the past few decades from the one-way permanent move to a typical destination country towards a very individual and dynamically evolving path. Due to accessible transport, communication and information technologies, the nurses, including the Czech ones, have many more opportunities for migration, including country hopping, commuting or circular migration to many countries around the globe (Schultz and Rijks, 2014). The case study of Šárka demonstrates the unpredictable and individual character of nursing migration - moreover, her migration career might not be completed, for she might migrate again in the future.

Consequences of migration

Freeman´s theory lists positive and negative consequences for the nurse and her/his family, for the health care systems and facilities in the destination and source countries, as well as for the nursing profession itself. General consequences, identical around the world, are described in Chapter 2[48]. Here I would like to highlight a few consequences especially relevant to the Czech situation.

Consequences of nursing migration for the Czech nurses, their families, the health care system and its users

As reported by Bratinková (Bratinková, 2011), many of the nurses in this study worked abroad as registered nurses in intensive care units, the majority reported an improvement of their professional skills and virtually nobody reported a deterioration of their professional skills due to migration[49], which is an interesting and potentially positive finding compared to some other studies (Cuban, 2010).

Almost all of the participants in the third qualitative strand of this study mentioned at some point that the early stages of migration were not easy, but that they were transformed by the migration. These transformation changes involved gaining new professional knowledge, skills and attitudes, as well as changes on a personal level, especially regarding an increase in self-confidence (Bludau, 2012), (Al-Hamdan et al., 2015) and reaching fluency in a foreign language.

Bludau demonstrated this professional transformation of the experienced migrant nurses in her study by their ability to appraise some incorrectly performed details from a daily nursing practice as incorrect, which might have not been the case previously (Bludau, 2014). Migrating Jordanian nurses reported virtually the same liberating experience of using the existing protocols to guide their professional behavior as well as an increase in their confidence and seeing more professional opportunities (Al-Hamdan et al., 2015). Similarly,

[48] Chapter 2. Literature review, 2.6.5

[49] Naturally, the nonrandom, self-selected character of my sample of respondents needs to be considered, and results should be interpreted with caution.

the Czech nurses in the third strand of this study mentioned how well-prepared nursing guidelines, protocols and standards of care can contribute to nursing autonomy and responsibility. The professional behavior of nurses, an officially higher level of nursing independence based on exact protocols of nursing care (standards of care) and friendly relationships at the workplace were viewed as positively contributing to work satisfaction, but as missing in the Czech system. Once the nurse experiences a truly respectful atmosphere at the workplace, it is apparently hard to accept anything less.

The reluctance of the returning Czech nurses to accept compromises in the above mentioned areas actually prevented them from staying in Czech nursing after they had returned to the Czech Republic and tried to re-integrate into Czech nursing. This has a serious negative consequence for the Czech health care system, as the respondents in this study were younger (the majority was between 30-40 years of age in 2014) with a potentially long career in the Czech health care system, and the retention of experienced health care professionals is an important goal in the time of shortages and beyond (Kroezen et al., 2015).

About one third of the Czech returnees felt that they could not use “any knowledge and skills from abroad” in the home country, 37% of the returning nurses were able to use “some knowledge and skills learned abroad” in the CR. Thus the Czech system is not very efficient at implementing innovations and exploiting this potential for improving itself. From this perspective, the important benefit of nursing migration for sending countries, the “brain circulation” (Kingma, 2006) of the returnees, is not fully exploited in the CR.

The reluctance to work again in the Czech health care system is also problematic for the returning and transformed nurse because her/his opportunities for employment are smaller, and in some rural areas non-existent, as noted by the participants in my focus group. Similarly, the positive consequences for the sending country in the form of sent remittances is not relevant in the Czech case.

According to Erikson, one’s identity develops between puberty and the early or mid-twenties (Illeris, 2013). A whole generation of Czech nurses was professionally educated and qualified by the Soviet model four year high schools, which the students entered at the age of 15. The students finished this type of school at the age of 19 as qualified nurses. Therefore, as

mentioned by the participants in the third strand, it is possible that some Czech nurses develop their first undistorted professional identity in Saudi Arabia by witnessing the professional behavior of their foreign colleagues.

Further, while their professional identity might have finally developed appropriately, the other parts of their identity could not be completely fulfilled in Saudi Arabia in accordance with their cultural background (e.g. as a woman, a mother, a Czech citizen) and at some point, the migrating nurses started exploring other possibilities of how to fulfil themselves. It can be demonstrated by the feeling that "*I have seen it all here*" and "*I've had enough here*" as described by Bratinková (2011). Also, some nurses described the migration to Saudi Arabia as "*definitely temporary,*" even though they have been on the move for five or nine years, where the perceived temporality could serve as a coping strategy. It is hard to choose and form an identity within all of the currently available choices suddenly offered to Czech nurses through migration, as one of the participants put it: "*new gates open in front of you*."

Bludau describes how the migration process (to Saudi Arabia) could generate self-worth and respect in migrating nurses, both of which the Czech nurses originally lack (Bludau, 2012). However, the equation is probably more complex than simple:

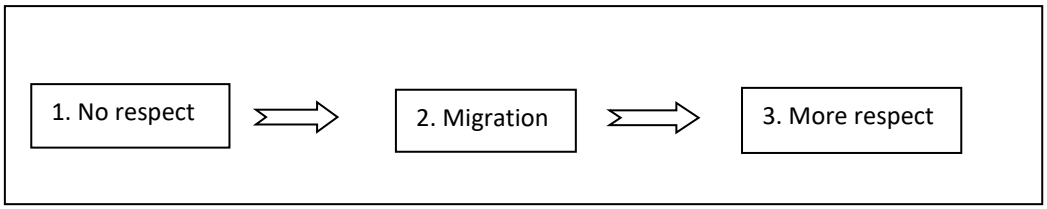


Figure 34. Respect in Saudi Arabia and in the CR

We can assume that Czech migrating nurses eventually experience a higher level of professional respect in Saudi Arabia than in the Czech Republic (this respect might be expressed for example as a "*competitive and beautiful salary*" or by being entrusted to carry out advanced nursing competences or working autonomously). However, we need to consider the organizational demands of migration, the initial professionally humbling experience (Davis and Nichols, 2002), (Jose, 2008), (Tregunno et al., 2009), (Bludau, 2010) and the concurrent and hardly acceptable disrespect and loss of human rights which females

experience in Saudi Arabia in general. I believe that the whole equation needs to be adjusted by other variables for it to be correct. For example, the resulting increase in professional skills, language skills, the related adventure, or the temporality of this arrangement might counterbalance the negative aspects of migration to this destination (Figure 35).

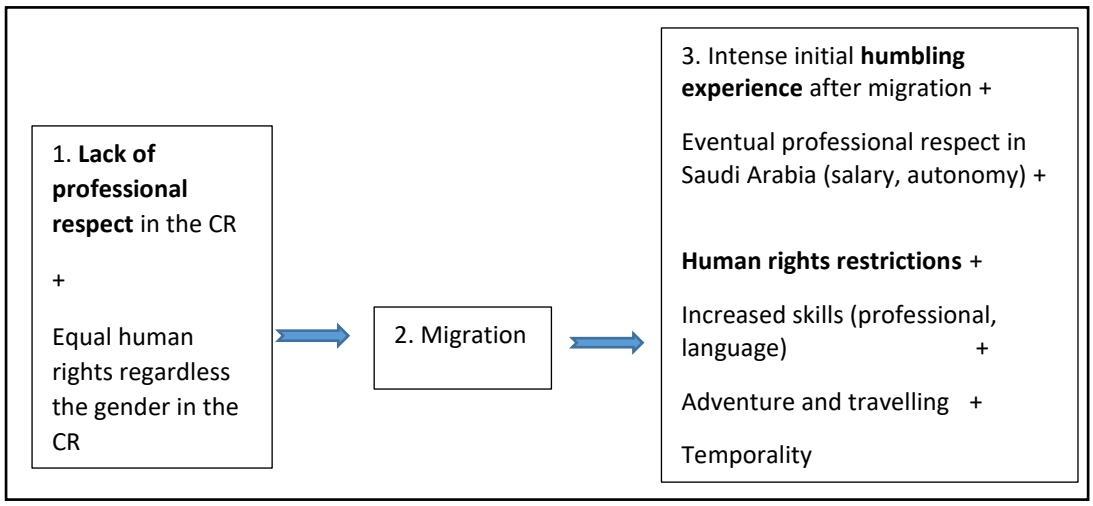


Figure 35. Respect in Saudi Arabia and in the CR

About 37% of the migrating nurses in this study did not have their own family (partner and children) when they migrated, therefore these immediate families were not negatively affected by the migration of a parent or a spouse to the extent demonstrated by Isaksen (Isaksen, 2012), and the impact on the other families (29% which stayed in the CR) was not assessed in this study.

A previous migrant is a highly mobile member of any workforce (Edwards and Davis, 2006). Only about one third of returning Czech nurses stated that they do not want to migrate again. Thus, a more intense migration of Czech nurses is possible, considering the currently deteriorating working conditions in Czech health care (ČTK, 2016). Even though this migration is currently temporary, as preferred by Czech nurses, the question remains as to whether they will really rejoin the Czech health care workforce in the future.

5.6 Conclusion

This conclusion summarizes the most important results and findings from this study, points out their relevance for both the Czech and global nursing situation, and stresses the importance of responding appropriately to the existing challenges.

Some findings from this study are rather similar to those of previously conducted research in this field, and some characteristics of Czech nursing migration differ substantially from those of the subjects of some of the published studies. Using the available monitoring mechanisms, the numbers of Czech nurses migrating and working abroad cannot be assessed accurately. It is very possible that we are able to see only a part of the picture, and many experienced Czech nurses could be working as undocumented caregivers in countries such as Germany and Austria. However, it appears that Czech registered nurses migrate as registered nurses in relatively smaller numbers, compared with nurses from other Central and Eastern European countries.

Unlike the results suggested by some other studies (Cuban, 2010), (Palese et al., 2010), a large proportion of Czech migrating nurses in this study did work abroad as registered nurses, and they reported that they gained new professional knowledge, skills and attitudes when abroad, as well as experiencing a personal transformation, with increased self-confidence and expectations of respect for their profession.

The Czech migrating nurses in this study stated a preference for temporary migration, and a return home after a few years spent abroad. This result can be biased by a higher number of nurses in this study migrating to a culturally very different country such as Saudi Arabia. Other Czech nurses who migrated to more culturally similar countries could be living in their host country without the wish to return to the Czech Republic (especially if they started a family there), and I was not able to reach these nurses for this study.

While it is clear that Czech migrating nurses are not a panacea for the many existing ailments of the Czech health care system, these returning nurses who were positively transformed by

migration can bring innovations (so called “brain circulation”) into the Czech health care facilities. They can affect the perception of the nursing profession by young nurses, by the general public and also by hospital managers as well as physicians. Participants in the focus groups mentioned different areas of nursing practice which seem to be more developed abroad and could be used to improve the Czech practice. Among these were, for example: an emphasis on professional nursing behavior, the provision of good palliative care, the organization of continuous professional development of nurses, and the ensuring of medication safety.

In any case, return migration is a rather difficult step, partly because the conditions and salaries in the home country are usually worse than those in the host country, which often was a factor leading to migration in the first place. Additionally, another issue reported by Bludau and mentioned repeatedly by the participants in my focus groups was the problematic acceptance of the returning nurses by their colleagues and also by supervisors and managers in a Czech facility, especially if the returning nurse tried to suggest some improvements or changes related to the local nursing practice. While the respondents in the second quantitative strand did not report major problems with being accepted by their Czech colleagues after return, a few mentioned that they deliberately withheld their international professional experience from their new colleagues in the Czech Republic.

If the skills of the returning nurses are to be utilized effectively as a potential source of improvement within the Czech health care system, the returnees need to be motivated not only to return to Czech nursing, but also to stay in it. The transformed nurses need time to be able to demonstrate and exercise their new skills in the Czech health care facilities, but they will not accept certain unsatisfactory working conditions, low salaries, and the lack of professional autonomy and respect in the long term. During their previous migration they were equipped with new skills, for instance with a fluency in a foreign language and nursing skills, and this will allow them to easily migrate out of the country or out of the profession again if they do not feel valued in the Czech nursing.

Quite a few of the migrating Czech nurses in this study returned to the Czech Republic to have children and spend their maternity leave in the CR[50]. While it is not clear how these nurses will behave once their children grow up, it is possible that many of these nurses will prefer that their children spend their childhood in the Czech Republic.

It is generally understood that nurses are vital for providing health care services, therefore we should value them better and offer them better working conditions. Simultaneously, we should fully use their potential, even though it might call for individual and innovative approaches. Šárka, the fictional nurse from the presented case study, has the ability to lead the nursing care in a coronary unit and implement the latest nursing procedures there. She is willing to return from migration and assume such a role. But she is not willing to waste her skills in the old fashioned approach to nursing in the Czech Republic, especially not for less than an average salary.

For this reason, the Czech professional organizations of nurses should systematically and uniformly present nursing to the Czech public and Czech decision makers as an autonomous and highly qualified profession, whose contribution to society deserves an appropriate remuneration. Bludau (Bludau, 2012) was correct in noticing the role of media in creating a distorted image of Czech nursing, which should be publicly addressed by the professional organizations of nurses. At the same time, the organizations should be vigilant of new and newly amended national legal regulations which can affect Czech nursing. These organizations should use its expert knowledge to argument for positive changes and the sustainable development of nursing aligned with international trends (i.e. the tertiary education of nurses (WHO, 2010a). These organizations should use its voice to protect future customers of health care and care services. Interestingly, transformed Czech nurses like Šárka seem to expect that the professional organizations will defend the interests of nurses and consequently that of their patients.

[50] Maternity leave is rather generous in the Czech Republic. The parent can spend up to three years at home with the child, the work position is held for the worker and the parent receives a monthly stipend from the state.

This call should be heard more than it currently is by the Czech decision-makers, politicians and regulators. If the current Czech politicians in power someday reject their fundamentally incorrect idea that the nursing shortage can be effectively solved by decreasing the qualifying education of nurses[51] (Hospodářské noviny, 2016), they could start exploring the global trend of well-defined advanced competencies for experienced nurses. This would need a change of current rules and support for the local managers in health care facilities to officially use the available human resources more effectively. The fact that Czech nurses returning from Saudi Arabia are nostalgic and want to return home should be grasped and capitalized on by Czech policy makers looking to encourage the retention of experienced and valuable health care professionals. Furthermore, it is vital that the decision-makers swiftly agree on implementing a viable strategy to increase salaries in this sector.

Czech health care managers should first ask the decision-makers to provide them with new policies aimed at motivating migrating nurses to return to Czech nursing. The managers are, in the end, responsible for providing safe services in their facilities, which means that they need to motivate the right people to start working there. This would, without a doubt, necessitate an improvement in salaries and working conditions, both of which are within the competencies of the local managers of health care and care services. Under the improved working conditions, the returning nurses could be slowly used in a "bottom up" approach to support development in Czech nursing practice, either in bedside positions or in lower managerial positions, such as a nurse in charge of one unit. Currently, however, returning nurses often face obstacles when attempting to use skills gained abroad.

Similar to other countries, the Czech Republic currently needs well-qualified health care workers who can flexibly react to many fast and unpredictable changes in the global society. A nurse in the 21st century needs to be a patient´s advocate, somebody who deals with bodily fluids appropriately, somebody in charge of high tech equipment, somebody correctly conducting nursing procedures, somebody very experienced in anticipating complications,

[51] A new law on the qualification of nurses is currently being negotiated in the Czech Republic. According to this law, the graduates from the qualifying education programs for health care assistants will be now called "practical nurses". If this program is complemented by another year of nursing studies, the graduate will gain the title of "general care nurse."

somebody highly social and compassionate, somebody efficiently documenting the details of provided care, somebody who makes decisions and is able to work in a team, somebody who justifies her/his activities by evidence in current research, and somebody conducting health promotion and embodying professional values (European Federation of Nurses Associations, 2015). But extreme time-sensitive demands are made of Czech nurses due to the shortage of health care workers, and all the while, these nurses are paid an average salary in the best case.

Surely, when the improvement of working conditions and salaries involves 100,000 people, it is a big political decision. But what are the alternatives? “No workforce, no health” (Buchan and Campbell, 2013) is hopefully a sufficiently clear message for those making decisions about their voters´ health.

5.7 Limitation of the study

The limitations of this study are detailed in Chapter 3 - Methods, Section 3.10. The main limitation of this study was the non-random and self-selected sample of respondents in the second quantitative strand, which is probably not representative of the total population of migrating Czech nurses. However, a convenient sampling frame was not available to me. The smaller than expected number of respondents in the quantitative strand and also the number of participants in the third qualitative strand were other limitations.

As recommended in the literature (Krueger and Casey, 2000a), I tried to analyze the focus groups´ discussion before the next focus group started. But due to a limited amount of time for this, and because of my then limited experience with this process, I was unable to pick certain topics out and explore them more intensely in the next focus group. This could have narrowed the spectrum of the obtained information. A few important topics were only revealed to me after putting all three focus group results together.

The main strength of this study is its complex mixed method approach and larger size, which was enabled by the fact that it was part of a PhD program. Additional value was gained

because it was conducted by a native nurse migrant, which offered extra insight into the world of (Czech) migrating nurses. The cooperation with a nationwide professional organization of health care professionals (the Czech Nurses Association), with the Czech Ministry of Health and with a Czech recruiting agency allowed me to gain insider knowledge which had not been previously assembled together.

5.8 Implication for the discipline and for practice

Czech health care is currently undergoing a severe shortage of workers, including highly qualified ones such as nurses and nurse specialists. The majority of Czech hospitals have had to close down parts of their units because there are not enough nurses to provide care (ČTK, 2016), (Šrajbrová, 2016).

For this reason it is essential to explore Czech nurses´ motives for migration and possibly also the factors facilitating return migration. As demonstrated in this study, Czech nurses do return from abroad (especially from Saudi Arabia), they return with new professional skills, knowledge and attitudes, they are primarily interested in working in Czech nursing and they have a potential to bring innovations into Czech theoretical nursing and naturally also into nursing practice. It seems that a nurse transformed by migration adopts a new professional identity, within which she starts to see nursing as a more interesting career.

However, their return is obstructed by the less flexible reactions of their coworkers and managers to suggested innovations. Thus, a clear implication for Czech nursing, should it at all profit from the temporary international migration of nurses, is that it needs to ensure suitable working conditions, offer decent salaries and probably start introducing advanced competences for nurses, through which the returning nurses could officially transfer their professional skills into the Czech health care system. Otherwise, Czech nursing will miss out on an important opportunity for development.

As mentioned in the study from Poland (Szpakowski et al., 2016), the Czech decision-makers and politicians do not pay sufficient attention to the looming threat where more Czech

nurses will react to the worsening of their working conditions by migrating to the nearby EU countries. While the data and analyses on Czech nurses´ mobility are limited, the easiest approach is to assume that their increased migration is very likely to happen and to try to prevent it with tangible incentives, which will be the same as suggested by Szpakowski: more competitive salaries and adequate working conditions with manageable workloads. Only then will the nurses be satisfied and stay, rather than undertaking the difficult journey of professional migration (Kingma, 2006).

5.9 Recommendation for future research

Considering the current situation in Czech nursing, a nationwide and randomized survey of registered nurses, using the data in the Czech Register for exploring the professional plans of the respondents, their migration history and intentions, could be feasible at this moment. This way we could more objectively explore the behavior related to international migration, the migration out of the nursing profession, as well as the other plans of Czech registered nurses. More importantly, we could assess the current extent of migration, with the goal to counteract the contributing factors and fight against the worsening shortage of nurses in the Czech Republic by using a more evidence based approach and well targeted retention policies.

A small-scale study (and thus, perhaps more likely to be funded[52]) would be a similarly randomized and multi-centric research project on graduating nursing students, exploring their intentions to migrate. This would be presented as a study exploring the general plans of the graduating nurses after finishing nursing school (e.g. whether the student will start working as a nurse immediately after finishing school, whether they have chosen a facility, certain unit or a department, whether they plan to work outside of the profession, or if they want to migrate). Such a study has not yet been published in the Czech Republic. Apart from attempting to quantify the intention to migrate, another interesting factor to consider would

[52] Given the current interest of the Czech decision-makers, politicians, health care facilities managers in the fact that nursing graduates enter the profession in smaller numbers than previously.

be to explore whether this generation also prefers temporary migration (only when pushed to do so by external conditions), or whether the young Czech population, which was not influenced by the socialist era, views migration and the concept of "home" differently. It is quite possible that because this generation grew up in a relatively open and interconnected world, surrounded by the English language and equipped with communication technologies, that migrating to a foreign country will be seen differently by them. Moreover, this generation studied English or German throughout their school career, including professional communication in English or German as part of their nursing curriculum. Compared to this, the generation of the currently most experienced and older nurses had Russian as the compulsory foreign language, but Russia is not a typical destination country for Czech migrating nurses.

The previous topic extends well beyond nursing science into general sociology research. Similarly, the sensitive topic of positive discrimination of nurses based on their ethnicity or nationality, which was described in the literature (Bludau, 2012) and appeared in my study as well, could be explored in another study with a non-nursing orientation.

Another useful study would be to explore and describe cases when a returning nurse was given competencies to implement changes in one area of Czech nursing practice based on her/his experience from international migration. The obvious goal would be to disseminate this practice to other places and bring innovations to the parts of the Czech health care system where they are needed. Here, it would be harder to find the positive case study/best practice examples, but it is surely worth the effort.

To be a migrant nurse is an amazing yet very difficult journey. The completion of this thesis was a similarly amazing and similarly strenuous journey, full of unexpected turns, during which I was transformed once again.

6 List of used abbreviations

CEE	Central and Eastern European countries
CGFNS	Commission of Graduates from Foreign Nursing Schools
CNNA	the Czech Nurses Association
CR	the Czech Republic
DNA	Did not answer (in the questionnaire)
e.g.	for example
EU	The European Union
EU8	Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia.
EU10	Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia and Bulgaria, Romania
EU12	Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia, Malta, Cyprus and Bulgaria, Romania
EU15	Belgium, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, United Kingdom and Austria, Finland, Sweden
FGs	Focus Groups
GDP	Gross domestic product
HCP	Health care professionals
HCA	Health care assistant
IC	Informed Consent
ICN	International Council of Nurses
i.e.	that is…
IENs	Internationally educated nurses
IOM	International Organization for Migration
MoH	Ministry of Health
NMC	Nursing and Midwifery Council
OECD	Organization for Economic Co-operation and Development

PhD	Doctor of Philosophy
Q	question
QMU	Queen Margaret University
RN(s)	Registered nurse(s)
nonRN(s)	Other professions/professionals than the RN
SA	Saudi Arabia
SAQ	Self-administered Questionnaire
SZŠ	Střední zdravotnická škola, Four year nursing high/secondary school
UK	the United Kingdom
UN	United Nations
US	North American
USA	the United States of America
UZIS	Czech governmental institute collecting and utilizing statistical data from health care sector, cooperating with WHO, OECD, the UN, EUROSTAT (UZIS., 2013).
WHO	World Health Organization

7 List of key terms´ definitions

Care worker - for the purpose of this text refers to a person providing "social services" to clients, which differ from health care services (help with activities of daily living – eating, dressing, movement, etc.)

Circular migration - describes the situation when the migrant returns home after a certain period abroad, but later migrates again.

Czech nurse responsible for general care – for the purpose of this study, this term will describe a nurse that obtained her/his first nursing qualification in the CR (or previously the Czechoslovak Socialist Republic). The term "Czech nurse" will be the shorter version of the term defined above.

Czech Register of Health Care Professionals – was established in the Act. No. 96/2004 Coll. as protection of public, is responsible for registering health care professionals wishing to practice their profession in the Czech Republic.

Flow of migrants – dynamic parameter assessing movement of migrants

Health care professional – for the purpose of this text refers to a highly qualified worker providing health care services

Health care worker – for the purpose of this text refers to a less qualified worker assisting with provision of health care services

Host country – destination country, receiving country of migrant nurse

Nurse responsible for general care – a term from the EU Directive 2005/36/EC

Orientation period – time when the newly hired general care nurse works with a designated experienced nurse tutor, it is intended for her/his adaptation to local nursing, usually lasting few weeks or months

Push and pull factors – factors stimulating or restricting migration in both, the source country and the host country

Return migration - return of persons to their country of citizenship after having been

international migrants (whether short-term or long- term) in another country and who are intending to stay in their own country for at least a year (United Nations, 1998).

Source country – country of origin, sending country of migrant nurse, home country

Stick and stay factors – similar to push and pull factors, but describing more personal reasons for migration decision to either stick with a home country or stay in the destination country (Tjadens et al., 2013)

Stock of migrants – total number of migrants at a given time and specified area

8 List of tables

9 List of figures and diagrams

10 List of Appendices

See Contents

10.1 Appendix A1 QMU Letter of provisional approval

Queen Margaret University
EDINBURGH

Name: Veronika di Cara
Status: PhD Student
Subject Area: Nursing
School: Health Sciences

Lucy Clapson
Registry Officer
Queen Margaret University
Queen Margaret University Drive
Musselburgh
East Lothian EH21 6UU

Tel: 0131 474 0000
Email: lclapson@qmu.ac.uk

11 January 2012

Dear Veronika,

Ethical Approval – Trends, Motivations and Experiences of Migrant Czech Nurses Responsible for General Care

The Research Ethics Panel has reviewed your application and Dr Jane McKenzie, Convener of the Panel, has confirmed that she is happy to take Convener's Action to grant ethical approval for your research, subject to you gaining a letter of access from the Czech Ministry of Health. Once you have received this please send a copy to researchethics@qmu.ac.uk and a letter can then be issued (via email) confirming ethical approval for your study. Please note that we must have this information before you begin your research.

As noted in the letter sent to you in December, please ensure that the QMU logo is included on all of your materials (information sheets, questionnaires etc).

Yours sincerely

Lucy Clapson
Secretary to the Research Ethics Panel

Cc Prof Jim Buchan, Supervisor

10.2 Appendix A2 QMU Letter of approval

Queen Margaret University
EDINBURGH

Name: Veronika di Cara

Status: PhD Student

Subject Area: Nursing

School: Health Sciences

Lucy Clapson

Registry Officer

Queen Margaret University

Queen Margaret University Drive

Musselburgh

19 January 2012

Dear Veronika,

Ethical Approval – Trends, Motivations and Experiences of Migrant Czech Nurses Responsible for General Care

Thank you for your response to the letter I sent you following consideration of your application by the Research Ethics Panel.

Dr Jane McKenzie, Convener of the Panel, has reviewed your response to the points you were required to address, and has confirmed that she is happy to take Convener's Action to grant full ethical approval for your research.

A standard condition of this ethical approval is that you are required to notify the Panel, in advance, of any significant proposed deviation from the original protocol. Reports to the Committee are also required once the research is underway if there are any unexpected results or events that raise questions about the safety of the research. Please find the appropriate form for this enclosed.

We would like to thank you for your co-operation and wish you well with your project.

Yours sincerely

Lucy Clapson
Secretary to the Research Ethics Panel

10.3 Appendix A3 Czech Nurses Association approval in Czech language

Vyjádření Vědecké rady ČAS k výzkumnému projektu

Řešitel: Mgr. Veronica di Cara, RN

Téma: Trendy, motivy a zkušenosti migrujících českých všeobecných sester

Řešitel provede výzkumné šetření formou dotazníků a pomocí focus groups. Účast ve výzkumném šetření je dobrovolná. Souhlas participujících organizací a sester se zapojením do studie bude získán předem. Účastníci focus groups budou participovat v diskusi pod číslem, nahrávky nebudou zneužity na veřejnosti.
V uvedených aktivitách nebudou zjišťovány žádné osobní či citlivé údaje.
Dotazniky budou na webové stránce ČAS a jejich vyplnění bude anonymní, potenciální respondenti budou informováni.
Tento projekt je plně financován výzkumniky.

Vědecká rada ČAS posoudila návrh projektu a **souhlasí** s jeho realizací.

Datum:

11. 1. 2012

Jméno a podpis:

Mgr. Hana Svobodová
Předsedkyně Vědecké rady ČAS

10.4 Appendix A4 Czech Nurses Association approval translated

Position of the Czech Nurses Association Research Committee on the research project

Researcher: Veronica di Cara, RN, MA

Topic: Trends, Motivations and Experiences of Migrant Czech Nurses Responsible for General Care

The researcher will use questionnaires and focus group meetings as research instruments. The participation of nurses and organizations in the project is voluntary. Consent with participation will be obtained before the research starts. The focus group members will participate in the focus group under an assigned number, the audio recordings will not be misused in public.

Any personal or sensitive data will not be collected in the mentioned activities.
The questionnaires will be posted on the web site of the Czech Nurses Association and their completion will be anonymous. Potential participants will be informed about this.

The project is being fully financed by the researcher.

The Research Committee of the Czech Nurses Association evaluated the proposed project and agrees with its realization.

Date:	Name and signature: [*Illegible signature]*
11.1. 2012	Hana Svobodová, MA The Chairman of the Research Committee of the Czech Nurses Association

I certify that the translation is accurate and identical with the text of the attached documents.
Translated by Veronika Di Cara, 12/1/2012

10.5 Appendix B1 Informed consent in qualitative strands in Czech language

Queen Margaret University

EDINBURGH

Informovaný souhlas

"**Trendy, motivace a zkušenosti migrujících českých sester: smíšený výzkum**"

- Přečetl/a jsem a porozuměl/a jsem informačnímu letáku a tomuto informovanému souhlasu. Měl/a jsem příležitost klást otázky o mé účasti v této studii.
- Rozumím, že účast v této studii je zcela dobrovolná.
- Rozumím, že mám právo kdykoliv ze studie odstoupit bez udání důvodů.
- Souhlasím s účastí ve studii. Rozumím, že mé osobní údaje jsou k dispozici pouze výzkumníkovi a všechny uvedené informace jsou přísně důvěrné.
- Souhlasím s pořízením zvukové nahrávky focus skupiny. Rozumím, že poskytnuté informace budou shrnuty ve zprávě, která bude publikována. Mohu dostat kopii této zprávy.

Jméno účastníka: _____

Věk účastníka: _____

Vzdělání účastníka: _____

V jakém oboru ošetřovatelství pracujete? _____

Podpis účastníka: _____

Podpis výzkumníka: _____

Datum: _____

Kontakt na výzkumníka:

Jméno výzkumníka: Mgr. Veronika.Di Cara

Email: vdicara@qmu.ac.uk

Adresa:

Postgraduate Student, Nursing, School of Health Sciences

Queen Margaret University, Edinburgh

Queen Margaret University Drive, Musselburgh,

East Lothian, EH21 6UU, Velká Británie

Kontakt na nezávislého poradce:

Jméno poradce: Mgr. Alena Šmídová

Email: alena.safrankova@seznam.cz

10.6 Appendix B2 Informed consent in qualitative strands in English language

Queen Margaret University
EDINBURGH

Consent Form

"Trends, Motivations and Experiences of Migrant Czech Nurses: a Mixed Methods Study"

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study. I understand that my personal information will be available only to the research team and that all of the information provided is strictly confidential.

I agree with the audio recording of the focus group proceedings. I understand that the provided information will be compiled into a report, which will be published. I can receive a copy of the report.

Name of participant: _____

Age of the participant _____

Level of education _____

In which area of nursing do you work? _____

Signature of participant: _____

Signature of researcher: _____

Date: _____

Contact details of the researcher:

Name of researcher: Veronika.Di Cara

Email: vdicara@qmu.ac.uk

Address: Postgraduate Student, Nursing, School of Health Sciences, Queen Margaret University, Edinburgh, Queen Margaret University Drive, Musselburgh, East Lothian EH21 6UU

Contact details of the independent adviser:

Name of adviser: Mrs. Alena Šmídová

Email: alena.safrankova@seznam.cz

10.7 Appendix B3 Information sheet for participants in the focus group in English language

Queen Margaret University
EDINBURGH

Information Sheet for Participants in the Focus Group

Dear colleague,

My name is **Veronika Di Cara**, I am a Czech nurse and also a PhD student at the School of Health Sciences at Queen Margaret University in Edinburgh, Scotland.

As part of my PhD thesis I am currently conducting a study with the title: **Trends, Motivations and Experiences of Migrant Czech Nurses: a Mixed Methods Study,** which investigates aspects of migration of Czech nurses responsible for general care. Such data are currently not available, yet they are necessary for workforce planning and development purposes. The Czech Nurses Association supports this project.

If you obtained your first nursing qualification in the Czech Republic (or previously Czechoslovakia) and have ever worked, or are currently working, as a nurse responsible for general care outside of the CR, you fulfill the criteria for participation in this focus group discussion.

What does it mean to participate in a focus group?I will organize a meeting in Prague or Brno, and you will be able to choose which date is convenient for you. At this meeting we will be talking together with a few other nurses in depth about your experience of working abroad as a nurse, and (if applicable) returning to the Czech Republic. The meeting will take approximately 90 minutes, and refreshments will be served. The meeting will be audio-recorded in order to ensure a complete collection of the information.

The participation in the focus group is fully voluntary. You will be free to not answer a certain question if you wish. You will be free to withdraw from the group at any stage and you would not have to give a reason. If you agree to participate, please sign the attached Informed Consent.

All data will be treated as confidential, only the researcher will have access to it (the recordings and the consent forms). Before publishing the results all data will be fully anonymised, so that nobody can be recognized.

The risks associated with this study are minimal. It is possible though that some sensitive issues might be discussed during the focus group. This study was approved by the University´s Ethics Committee and by the Czech Nurses Association Committee.

If you would like to contact an independent person who knows about this project but is not involved in it, you are welcome to contact Mrs. Alena Šmídová, the previous Czech Chief Nursing Officer.

Thank you very much for your time and interest! Sincerely, Veronika Di Cara

Contact details of the researcher:	**Contact details of the independent adviser:**
Name of researcher: Veronika.Di Cara	Name of adviser: Mrs. Alena Šmídová
Email: vdicara@qmu.ac.uk Address: Postgraduate Student, Nursing, School of Health Sciences, Queen Margaret University, Edinburgh,Queen Margaret University Drive, Musselburgh, East Lothian EH21 6UU, UK	Email: alena.safrankova@seznam.cz

10.8 Appendix C1 Information sheet for the first qualitative strand and questions for the semi-structured interview (Recruiting agency)

Queen Margaret University
EDINBURGH

Dear colleagues,

My name is **Veronika Di Cara**, I am a Czech nurse, a member of the Czech Nurses Association and also a PhD student at the School of Health Sciences at Queen Margaret University in Edinburgh, Scotland. A letter from my university confirming my status is attached.

I am currently conducting a study with the title: **Trends, Motivations and Experiences of Migrant Czech Nurses: a Mixed Methods Study**, which investigates the out-migration patterns of Czech nurses responsible for general care.

The findings of this study will inform us about the numbers of Czech nurses working outside of the Czech Republic (CR), their reasons for migrating and whether they tend to return to Czech nursing. Such data are currently not available, yet they are necessary for workforce planning purposes. Relevant ethics committees approved this study. **The Czech Nurses Association supports this project.**

I would like you to ask you to answer the questions related to migration of Czech nurses on pages 2-4 and add any other comment you may consider important.

If you have any further questions or wish to contact the researcher, please don't hesitate to use my email address bellow.

If you would like to contact an independent adviser, who knows about this project but is not involved in it, you are welcome to contact Mrs. Alena Šmídová, The Head of the Nursing Department at the Czech Ministry of Health.

Thank you very much for your cooperation, Veronika Di Cara RN, MA

Contact details of the researcher

Name of researcher: Veronika Di Cara

Address: Postgraduate Student, Nursing, School of Health Sciences
Queen Margaret University, Edinburgh
Queen Margaret University Drive
Musselburgh, East Lothian EH21 6UU, Scotland

Email: vdicara@qmu.ac.uk

Director of Study Name: Prof. James Buchan

Email: jbuchan@qmu.ac.uk

Contact details of the independent adviser

Name of adviser: Alena Šmídová

Address: VZV, MZČR

Palackého nám. 4, 128 01, Prague 2, Czech Republic

Email: alena.smidova@mzcr.cz

A guide for a semi-structured interview with a Czech-recruiting agency (V12/2012)

Goal**: to map the trends in nurse migration from the perspective of a recruiting agency.**

This Czech agency specializes in the recruitment of health care professionals predominantly to the Gulf region. It has been operating on the Czech market for more than 5 years and so far has placed over 500 health care professionals abroad.

1. What have been the numbers of Czech nurses responsible for general care[53] that found a nursing job abroad through your agency annually since 2005?

2005:	2008:	2011:
2006:	2009:	2012:
2007:	2010:	

Could a single nurse be placed by your agency more than once a year?

2. To which countries do these nurses migrate? How many nurses migrate to each of these countries?

[53] that obtained their first nursing qualification in the Czech Republic (or previously Czechoslovak Socialist Republic)

3. Do the nurses usually get 1 year contract from their employer?

4. Do these nurses need a qualification verification certificate issued by the Czech Register of Health Care Professionals?

5. Can you estimate the age structure of the nurses placed abroad by your agency?

6. How many of the nurses placed abroad by your agency hold:

   DiS title:

   BSN degree:

   MA degree:

   PhD degree:

   How many graduated only from a 4-year nursing high school:

   How many had a specialist education:

7. Do you have any evidence that these nurses later return to the CR?

7a. After how many years do they usually return?

7b. Approximately how many nurses return back to Czech health care facilities?

7c. Approximately how many returns to private and how many to public facilities in the Czech Republic?

7d. Approximately how many nurses return to Czech bedside nursing?

7e. Approximately how many assumes managerial or teaching positions in the Czech Republic?

8. Do you witness a repeated migration of Czech nurses - after they returned from one placement, do they request a second placement in the same country or in a different country?

9. Are the patterns of migration and return migration different and specific if the nurse migrates with her family? Is it common that the nurse migrates with her/his family?

10. Do the newly migrating Czech nurses prefer foreign health care facilities with an established network of Czech nurses?

11. Do you witness that the Czech nurses first move to large Czech cities before an international move?

12. According to you, is there any evidence that the professional skills of the migrating Czech nurses change while working abroad?

13. Did you notice a change in the demand to recruit and import nurses since 2009 as a result of the global financial crisis?

14. Can you describe the cooperation with the Ministry of Social Affairs, regarding reporting the numbers of placed workers annually?

15. Can you estimate what percentage of the Czech market in recruiting services do you cover? How many other agencies are operating in the CR?

16. What are your views on the future trends of the migration of Czech nurses?

17. Additional comments:

Thank you very much for sharing the information with me!

10.9 Appendix C2 Information sheet for the first qualitative strand and questions for the semi-structured interview (Czech Register of health care professionals)

Dear colleagues,

My name is **Veronika Di Cara**, I am a Czech nurse, a member of the Czech Nurses Association and also a PhD student at the School of Health Sciences at Queen Margaret University in Edinburgh, Scotland. A letter from my university confirming my status is attached.

I am currently conducting a study with the title: **Trends, Motivations and Experiences of Migrant Czech Nurses: a Mixed Methods Study**, which investigates the out-migration patterns of Czech nurses responsible for general care.

The findings of this study will inform us about the numbers of Czech nurses working outside of the Czech Republic (CR), their reasons for migrating and whether they tend to return to Czech nursing. Such data are currently not available, yet they are necessary for workforce planning purposes. Relevant ethics committees approved this study. **The Czech Nurses Association supports this project.**

I would like you to ask you to answer the questions related to migration of Czech nurses on pages 2-4 and add any other comment you may consider important.

If you have any further questions or wish to contact the researcher, please don't hesitate to use my email address bellow.

If you would like to contact an independent adviser, who knows about this project but is not involved in it, you are welcome to contact Mrs. Alena Šmídová, The Head of the Nursing Department at the Czech Ministry of Health.

Thank you very much for your cooperation, Veronika Di Cara RN, MA

Contact details of the researcher

Name of researcher:	Veronika Di Cara
Address:	Postgraduate Student, Nursing, School of Health Sciences
	Queen Margaret University, Edinburgh
	Queen Margaret University Drive
	Musselburgh, East Lothian EH21 6UU, Scotland
Email:	vdicara@qmu.ac.uk
Director of Study Name:	Prof. James Buchan
Email:	jbuchan@qmu.ac.uk

Contact details of the independent adviser

Name of adviser: Alena Šmídová

Address: VZV, MZČR

Palackého nám. 4, 128 01, Prague 2, Czech Republic

Email: alena.smidova@mzcr.cz

A guide for a semi-structured interview with the Register of Health Care Professionals in the Czech Republic (V12/2012)

Goal: **to identify the scope of data in the Register, relevant to the migration of Czech nurses; to use this information to assess the trends in migration of Czech nurses.**

The Register was established in 2004 as part of the Czech Ministry of Health. It checks the credentials of health care professionals (including nurses responsible for general care) who are consequently allowed to use the title „Registered" and practice independently the appropriate profession. Upon an applicant request, the Register also issues a certificate confirming the compatibility of the applicant's professional qualification with the Dir. EU/2005/36. This certificate is required by authorities in other states in order to recognize the applicant's qualification. The number of issued certificates is currently the only method to monitor the outflow of Czech nurses. Information on the intended destination country is not collected. A survey of a sample of nurses on the Register could answer some of the questions related to migration, which currently cannot be answered from the aggregated data, was considered. However, it was concluded, that such a survey would exceed the scope of this PhD project.

1. **What was the number of requests for qualification verification made to the register by nurses responsible for general care that obtained their first nursing qualification in the Czech Republic (CR) (or previously Czechoslovak Socialist Republic),**
   in 2010:

   in 2011:

   in 2012:

2. **Approximately, what percent of the nurses requesting the qualification verification are male? How does it relate to the general ratio on the register?**

3. **Which age cohorts are requesting the qualification verification the most often?**

4. **Do you know the average highest nursing education of the applicants?**

5. **Do you have any evidence that Czech nurses apply for re-registration, after they return from abroad? Can their numbers be estimated?**
   -

6. **Can it be estimated (based on the information from the form "Request to Issue a Certificate for Provision of Health Care Services without Supervision" submitted by Czech nurses):**
   - approximately how many nurses report to have an employer outside of the CR every year, from 2005 to 2012?

   - approximately how many nurses report to have gained post-qualification nursing education outside of the CR every year from 2005 to 2012?

7. **Can an estimation of the international migration of Czech nurses be made based on data other then the number of requests for qualification verification?**

8. **Are there countries that do not require the migrating nurse to show the verification certificate? Do you think some Czech nurses migrate without applying for the verification certificate?**

9. **Can some nurses be counted twice in your statistics?**

10. **In your opinion, what are the drivers of the Czech nurses migration?**

18. **What are your views on the future trends of the migration of Czech nurses?**

11. Additional comments:

Thank you very much for sharing the information with me!

10.10 Appendix C3 Self-administered questionnaire in English language

ajdotaznik150114naostro.pdf

10.11 Appendix C4 Self-administered questionnaire in Czech language

cjdotazníknaostro150114.pdf

10.12 Appendix C5 Topic guide for focus groups in English and Czech language

Engagement question:

In which country(ies) did you work and in which field/unit? (Short and easy question about a fact rather than an opinion to make people comfortable speaking)

Initial question:

Where would you go if you were to migrate again? (to introduce the FG theme)

Key questions:

1. **Based on your experience, which nursing skills and nursing knowledge gained abroad should definitely be transferred to the Czech health care system?** Probe: What experience leads you to this opinion? Can you give me an example

2. **Can you comment the opinion that, after a couple of years spent abroad, Czech nurses are less likely to return to their home country as compared to nurses who stay only one or two years?**

3. **Can you identify some factors which (would) motivate the migrating nurses to return to working in the Czech health care system?**

4. **What do you think about the statement "A common reason for Czech nurses migration is the improvement of their foreign language skills"?** Probe: Can you name some reasons for wanting to improve their language skills? In which sense is the command of a foreign language going to influence a migrant´s (nursing) career?

5. **What do you think about the possibility for a career advancement of the Czech nurses while still abroad?** Probe: Can you give us an example of Czech nurses assuming or not assuming managerial or more responsible positions abroad?)

6. **There have been some interesting findings regarding to the workplace discriminatory practices in the host country. In your opinion, do the Czech nurses experience this compared to the migrating nurses from other countries?**

Exit question: Is there anything else, which is important to know about Czech migrating nurses you would like to mention?

Focus Group Questions in Czech language

Engagement question:

V jaké zemi nebo zemích jste pracovali a na jaké jednotce?

Initial question:

Kdybyste nyní znovu odcházeli pracovat do zahraničí, do jaké země by to bylo?

Key questions:

1. Které sesterské znalosti a dovednosti používané v zahraničí by podle vašeho názoru měly být rozhodně přeneseny do českého zdravotnictví? Probe: Jaké zkušenosti vás vedou k tomuto názoru?
2. Můžete se vyjádřit k názoru, že po více letech strávených v zahraničí mají české sestry menší tendenci vrátit se do ČR?
3. Mohli byste identifikovat faktory, které motivují české sestry k návratu do českého zdravotnictví?
4. Co si myslíte o výroku: "Častým důvodem odchodu českých sester do zahraničí je zlepšení jejich znalosti cizího jazyka"? Probe: Můžete vyjmenovat některé důvody, proč sestry chtějí zlepšit svou znalost cizího jazyka? V jakém smyslu ovlivní znalost cizího jazyka (sesterskou) kariéru migrantky?
5. Co si myslíte o příležitostech českých sester ke kariérnímu postupu v zahraničí? Probe Můžete nám dát příklad jak české sestry v zahraničí zaujímají či nezaujímají managerské či jiné vyšší pozice?
6. Výsledky týkající se diskriminace na pracovišti v zahraničí jsou relativně zajímavé. Zažívají, podle vás, české sestry tuto diskriminaci v porovnání s migrantkami z jiných zemích?

Koncová otázka:

Existuje ještě nějaký jiný aspekt migrace českých sester, který je podle vás zásadní a měl by být zmíněn?

10.13 Appendix C6 Focus group protocol for recording nonverbal behavior

Migration of Czech Nurses - Focus group no. 1

Date: Time: Place:

Question	Participants	P 1	P2	P3	P4	P5	P6	P7	P8	P9
Q1.	V jaké zemi a na jaké jednotce jste pracovali? Příští migrace kam?									
Q2.	Přenos sesterských dovedností a znalostí do ČR									
Q3.	Víc let v zahraničí =menší tendence k návratu do ČR									
Q4.	Faktory motivující k návratu do českého zdravotnictví									
Q5.	Důvod k odchodu do zahraničí je zlepšení znalosti cizího jazyka									
Q6.	Příležitost českých sester ke kariérnímu postupu v zahraničí									
Q7.	Diskriminace Češek na pracovišti v porovnání s jinými migrantkami									
Q8.	Jiný zásadní aspekt migrace českých sester, který by měl být zmíněn.									

legenda	proxemika,paralinguistika, haptika….
zahajuje	1
účastní se	/
vyjádřil souhlas	+
vyjádřil nesouhlas	x
Smích	S
vzdechy	V
mračí se	M
nadšení	N
zvýšený hlas	ZH
křičí	K
přerušuje	I
mluví rychle	R
Mluví pomalu	P
Pauza	……..
zdůrazňuje	plat
naklání se	nákl.

10.14 Appendix D1 Example of coding in English

Two translated excerpts from raw transcripts to demonstrate the analysis process

Partial transcript of FG 2.

Date: 2/9/2015, place: ÚTPO, 1. Medical Faculty, Charles University

No. of participants: 4, Time: 18.00-19.10

Pages 11-13

M: …What do you think about the statement, that a common reason for migration of Czech nurses is to improve their language ability? What do you think? Do you agree with it or not?

N4: I completely agree

N5: Me too

N4: for me it was the priority, actually the extraordinary salary, the beautiful, huge salary on top, was a bonus. I really thought I will learn English and will go to some English speaking country, like primarily English speaking

N5: for me was a priority to experience something new, I perceived Saudi Arabia, my departure, I perceived it as a transition to the U.S.A. where I was for a while before, I spoke English quite well, but money was for me totally in the second place, it was also a bonus. But yes, girls I know which leave to Saudi give as one of the many reasons the language, simply to learn English

N4: I meet quite often these, who go for money

N5: yes, that also, but…

N4: I don't know, maybe, these I meet, it is fifty-fifty, maybe more these for money, than for language. But for me personally, language was the priority.

N3: well, here I partly agree , like half-half, because if one goes there and wants to do work of a registered nurse, she/he needs some command of the language, and it is not quite small, at least in Switzerland, they preferred level B2, well B1 was sufficient, but you had to reach B2 later. That

means, it´s not like the vocabulary of 100 words and learn there, that's why they did not take me to Saudi Arabia, because my English was simply not that good, that I could go there, that I got the chance.

M: uhm, anybody else?

N6: not really

M: no problem, just that you are not missed. Interesting, because they learn the language, that they wanted and then they come home, because they return a lot, especially from the Saudi Arabia. What is behind it? It is a kind of circle, isn't it?

N4: that's where your plans get spoiled, I did not plan to come home from Saudi, I planned to go to Australia, maybe America, Australia was the priority for me, then I firstly realized that I don't want to Australia, it is too far, secondly, I got my family, so that's were my plan got kind of spoiled

N5: do you mean when it changes, that you wanna learn English there…

M: …you say: "I go there because of the language", OK, but they return then and what do you do with the language in the nursing profession in the Czech Republic? If I leave with the goal of learning the language and then I return, even though N4 says that "originally she did not want to return", but many do return, now they know the language, somehow it does not make sense, does it….

N5: yes, but the people perceive it so (…) I don't know if its relevant, but my friend a nurse left for a year to Australia, to learn a language, now she is back, she know the language now, the fact that we all know that the language skills in Czech health care is just a nice bonus, everybody pats you on your back, but practically you can not use it, this is perceived before the return home as very abstract. He is enriched on the personal level, I think, the nurses are glad to learn English so they can communicate during their holiday and they don't perceive it like: ´is it gonna be useful professionally or not´. After their return they realize that it would be good to utilize this skill. I realized this, but my departure was motivational, language was secondary, its improvement, I did not care about this.

N3: I also had the language improvement for certain personal feeling, that I know the language on certain level, not only the school level of German in this case. They say, how many languages you know so many times you are human, so to be human once more and use the work, to travel somewhere for a year and only study the language it is not quite

possible, one doesn't have the money for that, when is connected with the work, you connect the pleasant and the useful, if I can say it so, so that. So it was not meant so that one understands a German-speaking patient in the hospital. But it happened to me once and it was nice. I felt kind of more self confident, because one of the twenty nurses in the unit I can communicate with him, it is like a bonus

M: but unpaid, isn't it , here in the Czech Republic, here it is only for you, isn't it...

N6: I think, that primarily you go there with the goal of learning the language, but then I felt, that you get a completely different interface in life, and different like, I felt, we are here kind of enclosed and as soon as we left there, all gates to all possibilities got fully open for us..

N5: Absolutely!

N6: …and you suddenly see different priorities, see everything differently than in the Czech Republic, because of that, you re-consider, what will be kind of next, you start to travel (smiles),

N4: I think that you bring back lots of, I for instance don't feel completely burned out after all of these years, and I relate it to the fact, that I worked for years with people who were proud to be nurses, and we don't have so many of these, it is not just the language, personally I really feel that I brought back that I perceive the profession differently than it is perceived over here.

(…)

N5: right, I agree with you

Partial transcript of FG 3.

Date: 23/9/2015, place: ÚTPO, 1. Medical Faculty, Charles University

No. of participants: 4, Time: 18.00-19.20

Pages 5-7

M: …If they decide to return to the Czech Republic, why do they go into the health care? Some try it /to work as a nurse in direct care in the Czech health care/ but it doesn´t work but some go there. I wonder, what is it, that they manage and stay there, because obviously it is about the experienced workforce, what are we doing with the workforce…

N8: you like it, I like it, to hold their hands when they are sick

N9: Yes, you like it

N8: I want to go through this with them, you feel something in yourself too

M: So that's one: I just want to be a nurse, I will be a nurse here too, even though it is paid less

N7: I see this as the only reason (everybody laughs) I am sorry, but I feel it this way

N10: I think that many feel that they don't have any other choice (in overlap, expressing agreement)

N?: Absolutely

N10: the health care education is kind of one way street

N8: that you can not open a hotel

N9: If I can from my experience, when I was leaving to the States, I was a beginning researcher at the school of pedagogy. I studied to be a teacher of nursing subjects and I wanted to do pedagogy, and when I came back from the States I went directly to the nursing institute, because there I simply realized, that that's what I want to do, that I want to be near the patients and in a hospital, right,

naturally when I then taught nursing, the second stay aggravated this feeling. And when I taught at the university, I missed the patients a lot, as I said. I tried at least one day per week, I tried to transfer what I…. But very soon it collided and I left this unit after one year and I never return as a nurse to Czech health care to work shifts (…) because I didn´t find there what I was looking for, what I was used to, the competences, the independence, decision making, possibility to help etc, etc. And the nurses, I think it´s been said, maybe it is also that they know a lot and they would want to return and progress our nursing somewhere

N8: That´s what I want to say, that I learned something there and I hope I could use it here, maybe not really

N10: well I tried such return…

N9: maybe there are units, I am sorry, units where it is possible

N10: …because I took some special pediatric courses in Saudi Arabia, course aimed at anomalies in cardiosurgery in children. So I aimed it when I came back, that I, although I never worked with children, that I would try and the experience (…) The first day came a nurse and we were supposed to give a pill to a three months old, she took the pill, told me that they don't have the crusher, so she did it between her own teeth, that was something!!! (everybody expresses surprise) that it doesn´t need to be sterile. My eyes almost fell out of my sockets and then I had a night shift and I got a bucket and rag, that I should have washed the drawers and surfaces in the nursing station, so it is that I would share, that I was somewhere, I did not tell anybody, but of course it got there somehow and the view of my colleagues was distorted and their attitude was hostile, or I perceived it so. Time would probably help, but then you wonder if it is worth it.

N7: lets look at (…) the pill – such nurse cannot want more competencies, at this level

N10: Like, I did not have any extra expectations, but this, there were more moments like this /after returning to a Czech hospital/, when your eyes just pop out, what is just too much, and what is like – ok, maybe; but what you don't want be part of

N7: that´s true, I feel that many our nurses cause this, that people look down upon them, they are considered girls for everything, do you understand what I want to say? /people agreeing/ it is a question of certain level, some nurses are stuck on counting garbage cans in the halls, there are six and should be seven, she wastes lots of energy on this task …

N9: I would kind of understand, that they are pushed , that they have a task to carry out, but this is sheer ignorance, they don't realize at all, what they are doing…

N10: If somebody told me that I would not believe it

N7: I maybe meant priorities

N9: nono, I don't criticize it

N7: I meant priorities, if I get a task to count garbage cans in the hall, there are six and should be seven, she wastes lots of energy on this task but she should be solving problems with IV line infiltrating, or somebody's not well, has low blood pressure, I dont know, like a tunnel here (pantomimes a limited view)

N8: I call it filipino tunnel

M: They have it too?

N9: maybe they are formed this way

N7: I dont know, maybe it is not that intense anymore, but I experienced that

N8: They work 1000 shifts I work less, I dont have so many overtimes, I want to go for quality, not quantity and they approach it like this: „it´s been said that the cans are being counted now – lets count the cans." And I dont count the cans, I say "girls, I cant count cans now."

M: So the possible motives why to come back is, that I really want to be a nurse, then I hear there "I want to lifted it up somewhere higher, but is there the opportunity, maybe it is not possible because of the rest of the Czech health care; and then the rest, which will not find any other job, so they go back, because they don´t have any other chance, maybe they would prefer to be anywhere else. so

they don't speak about the fact they were abroad, go there and work and you would not have guessed that they were somewhere, because they adjust back

N10: they don't really have any other choice, either you say: "it is not worth it, I don't want to be a part of this" or you make the step back and you fall into it, there is no other choice

N8: It is wrong, it is better to work as a receptionist in a hotel, I thought, but I feel it's a real pity

N10: it is a real pity

N8: I learned something, I have certain level, I would then, the patients deserve to have it the right way, even if nobody is looking

N10: I don't know, maybe they feel threatened?

N8: that's another thing, many people feel threatened

N10: Mainly the people who come back, are not the type to boast with it

N8: or to be managers immediately

N10: absolutely, they want to do the work they like

N8: and which they are experts in

N10: but under these condition it is not possible, well for me it was not possible

N7: I was also asking myself why this hostile attitude, as soon as they know that you were abroad. I think that many of these who found out, would also want, but

N8: they don't have the courage…

R7: for whatever reason can not manage it, yes, I will not evaluate if it is the qualification, or time, or something about family, and they carry it inside, I would place it in the category no. one: envy

N10: I think it is the Czech mentality, that we mix everything up, just my feelings

N9: I think it is connected with a huge complex of this whole society.

Code	Color
2.1 Professional behavior versus task orientation	red
2.2 Nurses abroad are more independent	pink
2.5 Transformation	green
2.7 Relationship at workplace	dark blue
3.1 Abstract wish to learn a language	light blue
3.2 Money as a pull or just an extra bonus?	purple
3.3 Wish to experience something different	yellow
3.6 Health care systems abroad work more efficiently	grey
3.7 No interest in innovations for Czech Health care	lavender

10.15 Appendix E1 Time plan for the research project (5th version)

Veronika Di Cara - **PhD Time Plan 5** (revised 11/2013)

No.	Task	Details	Deadline
A.	Literature Review	Initial thorough review, to be updated continuously	March 2011
B.	Outline Proposal	- written, ready to submit (ethical approval QMU, CZ) (official letter from QMU – **data collection for research purposes)**	March 2011 December 2011 December 2011
C.	Probationary Assessment	Full research proposal, 4000-5000 words, submission Draft version, consultation Meeting with panel of assessors Resubmission of final proposal - consulting QMU statistician (methodology) - supervisors	27 January 2012 November 30, 2011 5-9 March 2012 29 June 2012 Early June
D.	Data Collection	**1.a** Preparation for a retrieval of information related to nurses' mobility from the Czech register (consultation with adviser) + **continuous lit review**	August 2012
		1.b Interview with a representative of the **Czech register**	October 2012
		2.a Preparation for retrieving data from a recruiting agency.	December 2012
		2b. Interview with a representative of a Czech **recruiting agency**	January 2013
		3.a Preparation of the questionnaire for **nurses working abroad** (CNA web-based, recruiting agency, colleagues, advertisement since December 2012 done12/13, article in a Czech nursing magazine done 11/12)	February 2013- November 2013
		3.b Pretesting the questionnaire (10 migrant Czech nurses)	December 2013
		Inform Research Ethics Panel of changes in the questionnaire, if necessary	December 2013
		3.c Posting the questionnaire on the web	February 2014
		3.d Return of questionnaires	March 2014
		4.a Questionnaire for Czech nurses **working in the CR** (asking nurses who remained in the CR if they know colleague(s) who migrated – It will not yield exact numbers	OMIT???
E.	Data Analysis	Analysis of the QUAN data, selection of topics for FGs	March 2014- May 2014
D.	Data Collection	**5.a Focus groups** preparation	June 2014

		Conducting 3 FG with circa 20 nurses in total (qualitative part of the study)	July-August/September 2014
E.	Data Analysis	Qual and mixed method analysis	October 2014-March 2015
F.	Writing	full time?	2015
G.	Defense		2016
I	Skills	course in MMR, participation in a FG?	

 Initial matriculation 18/9/10

10.16 Appendix F1 Face and content validity check

A questionnaire for Czech nurses responsible for general care that work or worked abroad (V11/13)

Goal: to assess Czech nurses´ motives for migration and return migration, the trends in migration of Czech nurses, exploring their experience of working abroad, to test migration theories on the subgroup of Czech nurses, and to collect demographic data.

The participation in this part of the study is completely voluntary and fully anonymous, unless the respondent wishes to give the researcher her/his email address in order to be later included on the list of the focus groups participants. The respondent is free to omit certain questions in the questionnaire if she/he wishes to do so or withdraw from the study at any time without any consequences. The information provided by them will not be traced. By filling out the questionnaire and submitting it, the respondent consents to participate in the study.

This questionnaire will be available in English and Czech language.

The questionnaire will be administered via SurveyMonkey app.

The link to the questionnaire will be accessible at the Czech Nurses Association web-site from …… until……..

Announcements:

Article in a Czech nursing journal (Florence)

Add in a Czech nursing journal (Florence)

Advanced notification letter will be sent to the potential respondents (via recruitment agency) circa 2 week before the beginning of the survey period

Reminder will be sent to all of the respondents (via recruitment agency) one week before the end of the survey period

The order of the answer options in the ranking questions is based on their alphabetical order in the Czech language

Queen Margaret University
EDINBURGH

ČESKÁ ASOCIACE SESTER
ČAS

Dear colleagues,

My name is **Veronika Di Cara**, I am a Czech nurse, a member of the Czech Nurses Association and a PhD student at the School of Health Sciences at Queen Margaret University in Edinburgh, Scotland.

I am currently conducting a study with the title: **Trends, Motivations and Experiences of Migrant Czech Nurses: a Mixed Methods Study**. The findings of this study will inform us about the Czech nurses working outside of the Czech Republic (CR), their reasons for migrating and whether they tend to return to Czech nursing. Such data are currently not available, yet they are necessary for workforce planning purposes. Relevant ethics committees approved this study. **The Czech Nurses Association supports this project.**

If you can answer YES to both of the following two questions, you fulfill the selection criteria and I would like to ask you to participate in my study by filling out this questionnaire.

1. Did you obtain your first nursing qualification in the CR (or previously the Czechoslovak Socialist Republic)?
2. Have you ever worked, or are you currently working, outside of the CR?
3.

The participation in the study is completely voluntary and fully anonymous, unless **you wish** to give me your email address. You are free to omit certain questions in the questionnaire if you wish to do so. It will take you approximately 15 minutes to complete the questionnaire. By filling out the questionnaire and submitting it, you are consenting to participate in the study.

If you have any further questions or wish to contact the researchers, please don't hesitate to use the email address bellow.

If you would like to contact an independent adviser, who knows about this project but is not involved in it, you are welcome to contact Mrs. Alena Šmídová, The Chief Nursing Officer of the Czech Republic.

Thank you very much for your cooperation, Veronika Di Cara RN, MA

Contact details of the researcher

Name of researcher: Veronika Di Cara

Address: Postgraduate Student, Nursing, School of Health Sciences
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Queen Margaret University Drive, Musselburgh, East Lothian EH21 6UU, Scotland

Email: vdicara@qmu.ac.uk

Director of Study Name: Prof. James Buchan Email: jbuchan@qmu.ac.uk

Contact details of the independent adviser

Name of adviser: Alena Šmídová

Address: VZV, MZČR, Palackého nám. 4, 128 01, Prague 2, Czech Republic

Email: alena.smidova@mzcr.cz

Questionnaire Migrating Czech Nurses

1 ab. In which professions do you (or did you) work abroad?

Please, select all answers that apply to your situation.

- ❑ As nurse responsible for general care (registered nurse)
- ❑ In other nursing profession (as health care assistant, nursing assistant, aide, carer, personal assistant, etc.)
- ❑ In a profession unrelated to nursing (as a nanny, waitress, cleaner, in a shop, office, factory, etc.)
- ❑ Other ……

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

❑

F2a. Why did you decide to work abroad as a nurse responsible for general care?

Assign points to <u>each answer</u> based on its relevance in your situation: 1 point – completely irrelevant, 2 points – rather irrelevant, 3 points - rather relevant, 4 points - very relevant.

- ❑ I wanted to gain a new <u>professional</u> experience
- ❑ I wanted new experience <u>in general</u>
- ❑ I wanted to improve my language skills
- ❑ I wanted to improve my economic situation
- ❑ I followed my partner/family abroad
- ❑ I was looking for better <u>working</u> conditions
- ❑ I was looking for better <u>quality of life</u>
- ❑ Other ……

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F2b. Why did you decide to work abroad?

Assign points to <u>each answer</u> based on its relevance in your situation: 1 point – completely irrelevant, 2 points – rather irrelevant, 3 points - rather relevant, 4 points - very relevant, as in 2b

- ❑ I wanted new experience <u>in general</u>
- ❑ I wanted to improve my language skills
- ❑ I wanted to improve my economic situation

- ❑ I followed my partner/family abroad
- ❑ I was looking for better working conditions
- ❑ I was looking for better quality of life
- ❑ Other……

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F3a. In which country do you work (did you work most recently) as nurse responsible for general care?

Select one answer.

- ❑ Austria
- ❑ Germany
- ❑ UK
- ❑ Ireland
- ❑ Saudi Arabia
- ❑ The USA
- ❑ Other: …….

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F3b. In which country do you work (did you work most recently)?

Select one answer.

- ❑ Austria
- ❑ Germany
- ❑ UK
- ❑ Ireland
- ❑ The USA
- ❑ Other: …….

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F4a. If you worked as a general care nurse in more countries please indicate in which ones:

Select all answers that apply to your situation.

- ❑ Austria
- ❑ Germany
- ❑ UK
- ❑ Ireland
- ❑ The USA
- ❑ Saudi Arabia
- ❑ Other: ……

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

5ab. If you worked in professions other than general care nurse in more countries please indicate in which ones:

Select all answers that apply to your situation.

- ❑ Austria
- ❑ Germany
- ❑ UK
- ❑ Ireland
- ❑ The USA
- ❑ Other: ……

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F6b. Did you apply for a recognition of your qualification to be able to work as a nurse responsible for general care (registered nurse)? If so, what was the outcome?

Select one answer.

- ❑ Yes, and my qualification was recognized
- ❑ Yes, but my qualification was not recognized
- ❑ Yes, I have just applied, but await the outcome
- ❑ No, I did not apply as it is a lengthy process
- ❑ No, I am not interested in applying
- ❑ No, I have not applied as I have to improve my language skills first
- ❑ Other ……..

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

7a,b When you were looking for a job abroad, you typically:

Select one answer.

- ❑ found a job yourself in an newspaper add
- ❑ found a job by visiting the facility personally
- ❑ found a job yourself via the internet
- ❑ used a friend's or acquaintance's recommendation
- ❑ used a recruiting agency
- ❑ other ……

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

8a,b. Will/did you use the money earned abroad to purchase a house, a flat, or its reconstruction?

Select one answer.

- ❑ Yes, I do/did that
- ❑ No, I do not/did not that
- ❑ I have not thought about it yet
- ❑ No comment

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

9a,b. What was your parents' attitude towards you decision to work abroad?

Select one answer.

- ❑ They mostly wanted me to work abroad
- ❑ They were neutral to my decision to work abroad
- ❑ They did not want me to work abroad
- ❑ My parents did not influence my decisions
- ❑ No comment

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

10a,b. Did anybody have a positive influence on your decision to migrate? *Select one answer.*

- ❑ Yes, friends who migrated earlier
- ❑ Yes, relatives who migrated earlier
- ❑ Yes, acquaintances who migrated earlier
- ❑ Yes, somebody else
- ❑ No, nobody
- ❑ No comment

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

11a,b. While working abroad, were/do you financially support/ing your family in the CR?

Select one answer.

- ❑ Yes, every month
- ❑ Yes, about every 6 months
- ❑ Yes, about once a year
- ❑ Only rarely
- ❑ No, never
- ❑ No comment

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F12ab. Approximately what percentage of your yearly salary did you give to your family in the CR?

Enter the number or select one answer.

- ❑ %
- ❑ I don't know, I am unable to approximate this.
- ❑ No comment

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

13a,b. If you went originally abroad because of <u>your</u> work, did you bring your partner/children with you?

Select one answer.

- ❑ Yes, I brought my partner/children with me
- ❑ No, my partner/children stayed in the CR

- ❑ I originally did not go abroad because of my work
- ❑ I did not have a partner/children at that time
- ❑ No comment
- ❑ Other ……

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F14a. What did you find difficult while working <u>abroad</u> as a nurse?

Assign points to <u>each answer</u> to express how difficult it is according to you: 1 point – very easy, 2 points – rather easy, 3 points – rather difficult, 4 points - very difficult.

- ❑ The adaptation to a new culture
- ❑ The communication in new language
- ❑ The different work practices and different approach to the nursing profession
- ❑ The professional/technical words and jargon in the foreign language
- ❑ The relationship with my supervisors
- ❑ The relationship with the other colleagues (doctors, helping personnel)
- ❑ The relationship with the other nurses
- ❑ The relationship with the patients/clients
- ❑ The relationship with the clients´ family
- ❑ No comment
- ❑ Other……

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F15a. When you first started to work as a nurse abroad, your language skills were:

Select one answer.

- ❑ completely sufficient, I communicated without any problems in all situation
- ❑ sufficient for dealing with the majority of the common issues, but not to deal with a sensitive or deeper problem
- ❑ not sufficient at all, I had problems to communicate about everyday issues
- ❑ I am not able to evaluate that

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F16a. After the "orientation period" in your first nursing workplace abroad you were:

Select one answer.

- ❑ able to work independently without any problems
- ❑ able to work independently with minor problems caused by the different approach to nursing
- ❑ able to work independently with minor problems caused by the different language
- ❑ not yet able to work independently
- ❑ No comment
- ❑ Other …….

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F17a. In your view, how do the nursing skills of the Czech nurses compare to the skills of the nurses working in the country where you worked most recently?

Select one answer.

- ❑ The skills of the Czech nurses are very often better than the skills of the non-Czech nurses
- ❑ Some skills of the Czech nurses are better and some are worse than the skills of the non-Czech nurses
- ❑ The skills of both groups of nurses are comparable
- ❑ The skills of the non-Czech nurses are better than the skills of Czech nurses
- ❑ I do not know, I am not able to evaluate that

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F18a. While working abroad as a nurse, did you encounter any kind of discrimination (e.g. isolating you, pretending not to understand you, treating you unfairly, verbal violence, physical violence)?

Select all answers that apply to your situation.

- ❑ Yes, repeatedly from the colleagues from other countries
- ❑ Yes, repeatedly from the host country colleagues
- ❑ Yes, repeatedly from my supervisors
- ❑ Yes, repeatedly from my patients/clients
- ❑ Yes, repeatedly from my employer (e.g. financial discrimination)
- ❑ Yes, repeatedly from somebody else, whom……
- ❑ Maybe few times in the beginning
- ❑ No, I never encountered that
- ❑ No comment

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4

Not relevant	Partially relevant	Quite relevant	Very relevant

F19a. While working abroad my professional skills have:

Select one answer.

- ❑ significantly improved
- ❑ moderately improved
- ❑ stayed at the same level
- ❑ moderately deteriorated
- ❑ significantly deteriorated
- ❑ I do not know, I am not able to evaluate that

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

20a,b. In general, how would you describe your work experience abroad?

Select one answer.

- ❑ Significantly positive experience
- ❑ Moderately positive experience
- ❑ ~~Neutrally~~
- ❑ Moderately negative experience
- ❑ Significantly negative experience

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

21a,b. How long in total did you approximately spend abroad?

- ❑ ……..years

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

22a,b. Did you <u>permanently</u> return to the CR after working abroad for certain time?

Select one answer.

- ❑ Yes
- ❑ Not yet
- ❑ No and I am not planning on it

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F23a,b. Why did you return to the CR?

Assign points to <u>each answer</u> based on its relevance in your situation: 1 point – completely irrelevant, 2 points – rather irrelevant, 3 points - rather relevant, 4 points - very relevant.

- ❑ I had reached my goals
- ❑ I wanted to start a family
- ❑ Because of my immediate family (children/partner)
- ❑ Because of my parents
- ❑ I just wanted to return home
- ❑ I was homesick
- ❑ Other …….

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F24a,b. Where do you work after returning to the CR?

Select one answer.

- ❑ Outside of the health care sector
- ❑ I do not work - maternity leave
- ❑ I do not work - unemployed
- ❑ In the direct patient care
- ❑ In the health care sector but not in direct care (e.g. teaching, management)
- ❑ In the health care industry (e.g. pharmaceutical company)
- ❑ Other …….

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F25a,b. Do you feel that you can use skills which you gained abroad in your current work position?

Select one answer.

- ❑ Yes
- ❑ Only some
- ❑ No
- ❑ I did not acquire any new skills abroad
- ❑ I do not know

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F26a,b. How did your colleagues accept you after your return?

Select one answer.

- ❑ Very well
- ❑ Rather well
- ❑ Neutral
- ❑ Not very well
- ❑ Not well at all

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F27a,b Are you thinking about migrating again?

Select one answer.

- ❑ Yes, as a nurse responsible for general care
- ❑ Yes, in other nursing profession
- ❑ Yes, in a job unrelated to nursing
- ❑ No
- ❑ I do not know
- ❑ No comment

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

28a,b. How old are you?

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4

Not relevant	Partially relevant	Quite relevant	Very relevant

29a,b. How old were you, when you went to work abroad for the first time?

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

30a,b. Are you:

- ❑ Female
- ❑ Male

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

31a,b. When you <u>first started to work abroad</u>, you were:

- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Widowed

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

32a,b. <u>Now</u> you are:

- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Widowed

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

33a,b. Your highest completed education is:

- ❑ 4 year nursing school (SZŠ)
- ❑ 4 year nursing school (SZŠ) and a specialization
- ❑ year nursing college (VOŠ)
- ❑ Degree Bachelor of Nursing
- ❑ Masters degree
- ❑ PhD degree
- ❑ Other……..

Please rate the relevance of this item to the topic of Czech nurses migration on the scale below

1	2	3	4
Not relevant	Partially relevant	Quite relevant	Very relevant

F34a. If you would like to participate in a focus group related to the topic of Czech nurses migration, you can enter your email address here

……

35a,b. Any other comments you wish to share with the researcher?

Thank you very much for completing the questionnaire!

Face validity

1. Please describe what this instrument (questionnaire) seem to be measuring:

Content validity

1. According to your expertise, are all of the dimensions of the Czech nurses migration covered in this questionnaire? Which topic is missing?

10.17 Appendix G1 Additional tables and figures

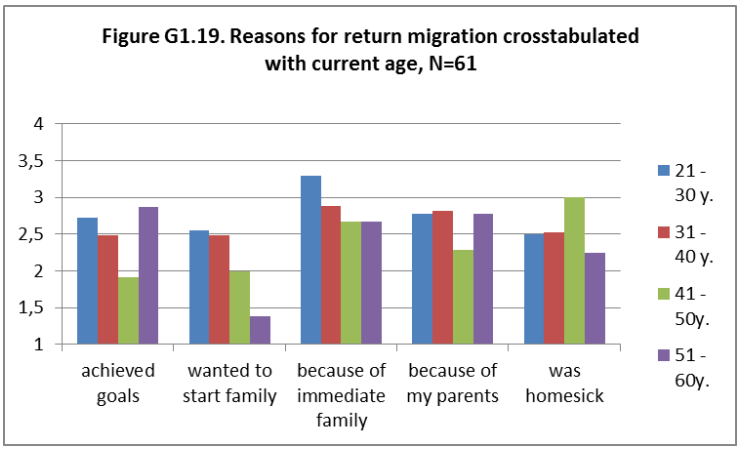
Table G1.46. Respondents´ gender

	completely irrelevant	rather irrelevant	rather relevant	completely relevant
New professional experience (n=81)	7% (n=6)	14% (n=11)	39.5% (n=32)	39.5% (n=32)
New life experience (n=82)	2% (n=2)	15% (n=12)	23% (n=19)	60% (n=49)
Improve language ability (n=80)	2% (n=2)	10% (n=8)	20% (n=16)	68% (n=54)
Improve economic situation (n=82)	4% (n=3)	13% (n=11)	23% (n=19)	60% (n=49)
Went abroad with partner/family (n=68)	75% (n=51)	6% (n=4)	4% (n=3)	15% (n=10)
Better working conditions (n=77)	13% (n=10)	21% (n=16)	23% (n=18)	43% (n=33)
Better living conditions (n=73)	15% (n=11)	25% (n=18)	29% (n=21)	31% (n=23)

Table G1.16. RNs´ rating of their reasons for migration (n=68-82)

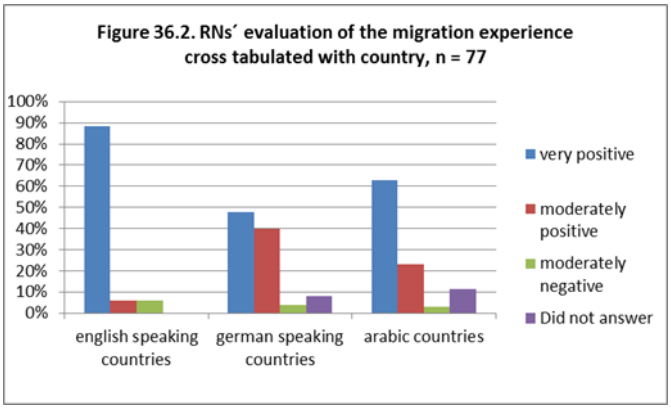
	completely irrelevant	rather irrelevant	rather relevant	completely relevant
Achieved my goals	26% (n=17)	19% (n=13)	29% (n=19)	26% (n=17)
Wanted to start family	44% (n=29)	14% (n=9)	15% (n=10)	27% (n=18)
Because of my immediate family	21% (n=14)	15% (n=10)	15% (n=10)	49% (n=32)
Because of my parents	20% (n=13)	20% (n=13)	30% (n=19)	30% (n=19)
I was homesick	16% (n=10)	30% (n=19)	32% (n=20)	22% (n=14)

Table G1.19. Czech nurses´ ratings of reasons for return migration, (n=65-61)



	very easy	rather easy	rather difficult	very difficult
new culture	10% (n=8)	46% (n=38)	33% (n=27)	11% (n=9)
foreign language	3% (n=2)	34% (n=28)	35% (n=29)	28% (n=23)
different nursing	2% (n=2)	40% (n=32)	43% (n=35)	15% (n=12)
technical words	2% (n=2)	36% (n=29)	43% (n=35)	19% (n=15)
supervisors	22% (n=18)	54% (n=43)	21% (n=17)	3% (n=2)
colleagues	22% (n=18)	54% (n=43)	21% (n=17)	3% (n=2)
nurses	31% (n=25)	51% (n=41)	15% (n=12)	3% (n=2)
clients	26% (n=21)	48% (n=39)	23% (n=19)	3% (n=2)
clients´ families	25% (n=20)	36% (n=28)	31% (n=24)	8% (n=6)

Table G1.22. RNs´ rating of certain migration aspects (n=82-78)



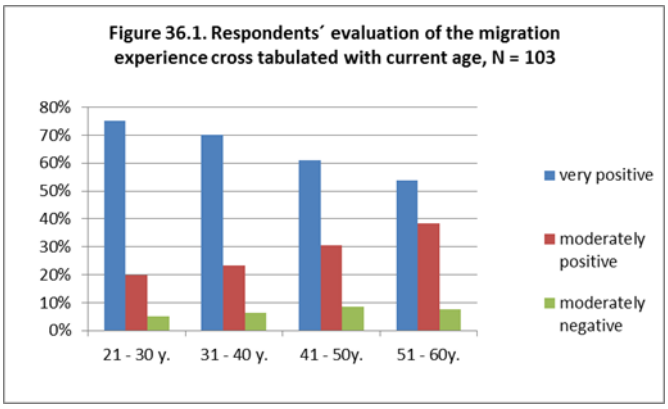


Figure 36.1. Respondents´ evaluation of the migration experience cross tabulated with current age, N = 103
80%
70%
60%
50%
40%
30%
20%
10%
0%
21 - 30 y.
31 - 40 y.
41 - 50y.
51 - 60y.
very positive
moderately positive
moderately negative

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